



Practice Policies

1. Payment Policy

Full payment is due at time of service. If you have insurance, we will bill your insurance company for payment after verifying eligibility and after you have paid your estimated co-payment portion. We offer third party financing through CareCredit and will be happy to help you apply for this if you need assistance. If your account balance becomes 90 days past due, your account may be handed over to a collection agency. You will be responsible for all costs of the collection process, as well as your portion of the dental services.

2. Insurance Claim Filing Policy

Your insurance policy is a contract between you, your employer and your insurance carrier. Our relationship is with you, the patient, and not with third party insurance company. We will bill your dental insurance as a courtesy to you. In the event they do not render payment, you are responsible to pay the balance on the account. When presenting you with a treatment plan, we include the estimated insurance portion. This is just an estimate. We do recommend a pre-determination on treatment that is over the amount of \$300.00.

3. Cancellation Policy

Our time is very important to us and our patients. If you are unable to keep an appointment, we expect a minimum of two business days notice. Should a failed or short notice cancellation occur, you will be billed \$50.00 per hour of your appointment time, and may be asked for non-refundable deposit of \$50.00 per hour of appointment time for future appointments.

4. Standard of Care Policy

We are professionally and legally held responsible for any negligent care we give to our patients, even if patients consent to treatment below the standard care. Your treatment plan will outline the best care possible and we will treat you with best care possible.

5. Record Policy

In accordance with Texas Law, patients are entitled to access copies of their records; however all original records remain the property of The Tooth Doctor. There is a fee required to cover the cost of duplication of patient records and x-rays.

Patient (guardian) Signature _____

Date _____