MIDTOWN
DENTAL
WELLNESS

Office Policies

Welcome! Our practice is committed to taking good care of your oral health. Your clear understanding of our financial policies and procedures is important to our professional relationship.

Please read below and **initial** the items once you fully understand our office policies.

Consent to Care

____ I wish to be treated by Midtown Dental Wellness. While I am a patient, I permit my doctor(s), the office employees, and all the persons caring for me in the ways they judge are beneficial to me. I understand this may include tests, examinations, x-rays, and dental treatment.

Missed/Canceled Appointments

____ Appointment times are reserved especially for you. When you make an appointment, please be sure that you will be able to keep it. If you cannot make an appointment, please notify our office **48 hours** before your appointment time or as soon as possible.
A charge of $100 will be automatically processed for any appointments canceled with less than 48 hours notice for your appointment.

Financial Agreement

____ We expect full payment at the time of visit for any co-payments estimated. I understand that my dental plan will ultimately process claims, and any balances due after the claim is settled is my responsibility. Therefore, a credit/debit card on file will satisfy any remaining balance after the insurance payment is received.

We will make every effort to get your dental claims paid. Any charges remaining unpaid after 60 days after the date of service are considered overdue.

_____ I agree to provide Midtown Dental Wellness accurate information of my insurance status, and allow my insurance company to assign benefits to Midtown Dental Wellness as necessary. I authorize Midtown Dental Wellness to release pertinent information to my insurance company when it is requested.

____ If it becomes necessary to forward an amount to a collection agency, I will also be responsible for the fee charged by the agency for the cost of the collection, in addition to the original amount due. This may amount to as much as 40% of the original fee.

_____ _____
Patient/Cardholder name Signature

_____ _____ _____
Credit card number Exp date Security code

_____ _____
Zip code Email address

_____ _____
Patient signature Date

_____

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