

Office Policies

Dr. Brad Pitts, DMD, LLC

So that we may provide you with outstanding customer service and care, please review the following policies:

Initial **Office Hours:** Monday through Thursday from 8:30am until 5:00pm (Closed for Lunch 1-2pm)

_____ **Payment is due when services are rendered.** We accept cash, checks, Visa, MasterCard, American Express and Discover. Additional financing is available pending approval through Care Credit.

_____ **Insurance:** We accept assignment of most dental plans. However, we do require payment of the **estimated** copayment portion of your bill at the time of service. After your dental plan processes your claim, you will be responsible for any remaining balance. Your policy is a contract between you and the insurance company. We are not a party to that contract. If your dental plan has not paid your account in full within 45 days, the balance must be paid once you receive your statement. Please be aware that some, and perhaps all of the services provided may be non covered services and may not be considered reasonable and customary under your dental plan. Our practice is committed to providing excellent patient care and our charges are usual and customary for our area. You are responsible for payment regardless of a dental plan's arbitrary determination of usual and customary rates. Please be advised that if your treatment is not covered under your specific plan, full payment is due at the time of service.

_____ **Adult/Minor Patients:** Adult patients are responsible for full payment of their estimated portion of fees at the time of service. The adult/parent/guardian accompanying a minor is responsible for payment at the time of service as well. Children under the age of 16 **MUST** be accompanied by a parent or guardian at all times. For unaccompanied minors, non emergency treatment will be denied unless charges have been prearranged.

_____ **Guarantee of Work:** Dr. Pitts guarantees restorative work for five years depending upon your maintaining individual home care needs. This is also contingent upon you keeping your recommended treatment and preventive care appointments. The non compliance of the above will make this guarantee null and void.

_____ **Missed Appointments:** We certainly understand that scheduling conflicts do occur. In order to prevent assessing a broken appointment fee of \$50.00, **we require 2 business days notice for cancellations.** For appointments on Monday, please call by Wednesday for appointment changes as our office is closed on Fridays. This time is reserved exclusively for you and is not shared with others. Please help us help you by keeping your reserved time. We now require a **\$100 deposit to appoint for any treatment over \$500.** This deposit is to reserve your appointment and will be applied to your total cost when treatment is completed. You will not lose this deposit if you need to cancel as long as you give 2 business days notification. Only cancellations with less than 2 business days notification will forfeit your deposit.

_____ **Billing Statements:** Statements are mailed once a month. We will also send you a statement when a payment is received from your dental plan to inform you of your remaining balance. Payment in full is expected on all statements, unless prior financial arrangements have been made.

_____ **Interest:** We reserve the right to charge interest in the amount of 1 ½% (18% APR) as provided by state law.

_____ **Returned Checks:** There is a \$25.00 charge for checks that are returned due to insufficient funds and payment will be immediately due in cash.

I have read and understand the above office policies and agree to all terms stated above.

X _____ Date _____
Signature of Patient or Responsible Party