Financial Policy

I understand that I am personally responsible for payment of all fees for services provided in this office for me or my dependents regardless of any insurance coverage. Accounts over 60 days will accrue a 1.5% monthly or 18% annual interest rate. Please know that delinquent accounts may be assigned to a credit reporting collection service. Please make any financial arrangements prior to treatment.

Appointment Scheduling and Cancellation Policy

Initials: _____

Our primary goal is to provide our patients with high quality dental care with an emphasis on individual attention. Patient responsibility plays a big role in successful treatment. Attending scheduled appointments and following dental home care recommendations will help in the results of a winning smile for years to come.

We do our best to confirm our patient's appointments by phone, text message or email. We strive to create a schedule that most efficiently provides for the dental needs of all of the patients we serve. We respectfully request 24 hours' notice to reschedule or cancel an appointment. This allows us the time to fill the appointment with a patient that is on the waiting list and to better serve the needs of all or our patients. **A late cancellation or missed appointment may be subject to a $100 cancellation fee for the first time and up to the full amount of the appointment for subsequent missed appointments**. We understand that situations occur that may hinder you from keeping your appointment and we are willing to work with you to find an appointment that works best with your schedule.

Initials: _____

Dental Insurance

Dental insurance is a contract between your employer and the dental insurance company. We encourage you to become familiar with your benefits and the details of your policy that are based on the terms of the contract that was negotiated between your employer and the dental insurance company. Dr. Molly and Dr. Carly are not preferred providers or contracted dentists with any insurance company (with the exception of being a Premier Provider with ODS/MODA). It is your responsibility to provide current insurance information in order for this office to submit claims on your behalf.

We will prepare and submit your dental insurance claims as a courtesy to you. We do not submit medical claims. We realize the complexity of dental benefits and we are here to assist you in making the most of your insurance without compromising quality dental care or dictating the treatment that Dr. Molly and/or Dr. Carly proposes. We will verify your dental coverage and obtain an approximate breakdown of benefits. We do our best to ***estimate*** your benefits and your portion due based on the information we receive. Please realize this is only an estimate. Insurance companies use a disclaimer that states "*all claims are subject to eligibility and plan provisions at the time the services are rendered. This is not a guarantee of coverage"*.

I authorize my insurance company to pay the office of Dr. Molly and Dr. Carly all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all claim submissions. I authorize the office of Dr. Molly and Dr. Carly to release all information necessary to secure payment of insurance benefits.

Initials: _____

I understand and consent to the dental treatment and associated financial responsibility for dental work performed by Dr. Molly, Dr. Carly, their hygienists and staff. I understand that I am financially responsible for all fees regardless of whether or not they are covered by my insurance. I have read, understand and accept the terms of the above outlined policies.

Patient/Parent/Guardian _____ Date: _____