WELCOME TO DAVIDSON DENTAL CENTER

You are about to receive the ultimate dental experience. Our practice offers state of the art technology, the finest sterilization equipment and a dental team who receives continuing education in the latest dental technology and procedures.

INFORMATION PERTAINING TO FINANCIAL POLICY

In order to continually provide a high caliber of service, we cannot offer in office financing. A treatment plan will be provided for you estimating the cost of the necessary dental treatment for you. We offer outside financing with a low interest rate. Prior approval by the financial company is necessary. Please inquire with the front office if you are interested in applying.
Since we do not finance balances in our office, **we do accept MasterCard, Visa and Discover as well as cash, personal checks and Care Credit.**

INFORMATION PERTAINING TO APPOINTMENT POLICY

Since each appointment time is reserved especially for each patient, a **48-hour** notice is necessary for cancellation of an appointment. Failure to provide a **48-hour** notice could result in a $50.00 charge for each **30-minute** segment of your reserved appointment time.

INFORMATION PERTAINING TO INSURANCE

We will file your primary insurance as a courtesy to you. Any co-pay, or percentage, that the insurance does not cover is due on the date the service is provided. If insurance coverage cannot be verified prior to your appointment, the total amount of the procedure will be due on the date the service is provided. **After 45 days, the full amount of the procedure will become your responsibility if insurance has not provided payment. We do not write of balances that are not covered by the insurance company.**

AUTHORIZATION OF PAYMENT

I have read and understand that **balances are not financed through the dental office and that I am fully responsible for the total fees of all services rendered** regardless of the amount paid by my insurance company. I understand there are fees for returned checks, for late payments and for appointments that are not cancelled within 48 hours of the appointment time. I understand that it is **my** responsibility at all times to know what my current status is with my insurance and any balance I may have. Balances carried for more than 60 days are subject to being issued to an outside agency for collections.

______________________________ Signature of responsible party

________________ Today's date

Davidson Dental Center

Acknowledgement of Receipt: “Notice of Privacy Practices”

You may refuse to sign this acknowledgement. However, if you do refuse, we will be unable to send any of your dental records or xrays to any other office or insurance company.

I, ________________________________, have received a copy of the
(Please print name)
Notice of Privacy Practices.

____
Signature

____
Date

For Office Use Only

We attempted to attain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

____ Individual refused to sign

____ There was a communication barrier which prohibited obtaining the acknowledgement

____ An emergency situation prevented obtaining the acknowledgement

____ Other (Please Specify) ______________________________