

EMAUS AVENUE FAMILY DENTISTRY

FINANCIAL POLICY

We will be glad to help you obtain the appropriate benefit from your insurance carrier, and bill your carrier for service. However; your deductible and copayment and uncovered services and any unpaid claim is your responsibility.

We will be happy to request pre authorization of benefits from your insurance carrier; routine treatment is done without submitting request unless you ask us to do so, and we will request pre authorization for all major dental work.

Patient who have no insurance are requested to pay for services as rendered unless prior arrangements have been made with the office manager.

Please give us at least 24 – 48 hours notice prior to any appointment cancelation.

We reserve the right to terminate the patient from the office if there are three broken/no show appointment.

Signature of patient _____ **DATE:** / /

(Parent or guardian if minor)

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that a copy of the office privacy practice has been made available to me; and I have a given the opportunity to ask any questions.

Signature of patient _____ **DATE:** / /

(Parent or guardian if minor)