



HIGHLAND DENTAL CLINIC

OFFICE POLICIES

Welcome to our dental clinic! We appreciate the opportunity to provide a dental home for you and/or your family and provide you with individualized and comprehensive dental care. We are dedicated to an excellent patient experience and require you to be familiar with and follow the below office policies:

APPOINTMENT REMINDER AND CANCELLATION POLICIES

I would prefer to receive appointment reminders via: (please circle one of the following)

☐ Cell Phone Call

☐ Home Phone Call

☐ Text

- It is your responsibility to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment.
- Please respond as soon as possible to appointment confirmations. If your appointment is still not confirmed less than 24 hrs prior we reserve the right to reschedule your appointment.
- We require a minimum of 48 hours notice per appointment for any cancellations or to reschedule your appointment.
- There may be times when our clinic may need to reschedule your appointment due to rare unforeseen circumstances. Please note we will make every effort to be as accommodating as possible when reserving a new appointment for you.

In the case that insufficient notice is given we reserve the right to charge a \$50.00 short notice cancellation fee that will not be covered by your insurance or benefit plan.

First time: this fee will be waived as a professional courtesy

Second time: \$50.00 will be applied to your account and must be paid prior to another appointment reservation

Third time: \$50.00 will again be applied to your account and must be paid prior to another appointment reservation

Should you miss any further appointments or cancel under 48 hours, we reserve the right to ask you seek dental treatment elsewhere and will forward your records to your new dental professional.

DIRECT BILLING INSURANCE & PAYMENT POLICIES

Many Insurance Providers prevent us from accessing information directly from your insurance carrier. It is **your** responsibility to know the details involved in your plan (annual maximums, benefit year, frequencies, other limitations).

We extend the courtesy to bill your insurance directly; however, to avoid discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to the maximum. To find out what your insurance plan covers, please consult your insurance app, contact the customer/member service department of your insurance company or your employer's human resources department.

You may request a pre-determination be submitted on your behalf to your insurance company for any major treatment planned. This will give you an estimate of what your insurance will pay for that treatment prior to getting the work done.

If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. Responsibility for payment for services rendered to any child/children/grandchild rests with the parent / guardian and/or the insurance benefit policy holder.

We accept cash, Debit, Visa, MasterCard & American Express. Continued on back...

PAYMENT OPTIONS

Below are 2 payment options available to you. Please circle which option you will participate in:

OPTION 1 — Payment is due in full on the day treatment is completed.

Your payment will be processed & insurance documents will be generated for you to submit to your insurance carrier. An insurance cheque will be sent directly to you from your insurance carrier. If you do not have insurance, then payment in full is expected at time of services, unless financial arrangements have been made in advance.

OPTION 2 — We will direct bill your insurance carrier. Please provide your credit card information below.

You will be required to leave a credit card number on file & any outstanding amount will be applied to that credit card once your insurance carrier has paid us its portion.

If we receive an explanation of benefits from your insurance carrier at your visit, you will be required to pay the outstanding balance before you leave.

If we receive an acknowledgement you will receive a statement from our clinic when your insurance company responds. Payment of the patient's portion of the balance is due upon receipt of statement. If you are dissatisfied with their payment, please contact your insurance carrier.

We will notify you of any charges prior to credit card processing and a receipt for payment will be emailed or mailed to you. Please notify us if there are any changes to your credit card information.

Our clinic will file both primary and secondary insurance claims for dental services rendered. Any balance left over is the patient's responsibility.

FEE INCREASES

Each January, our office will increase fees to keep in line with insurance carrier increases and the Alberta Dental Association Fee Guide. Any estimate (pre-determination) for treatment prior to January 1st will be recognized until March 1st of the New Year, after that any outstanding treatment estimates will be increased to follow the current year's fees.

COLLECTIONS

All accounts 90 days or more past due without a payment plan in place will be turned over to a collection agency and the dental clinic may cease providing services to you. The patient will be responsible for all costs involved in the collections process. The patient or parent / guardian understands that the clinic has the right to disclose all relevant information for these proceedings.

I have read & understood the above policies.

Patient Name: _____ Date: _____

Patient / Parent / Guardian Signature: _____

[OPTION 2 ONLY]

I hereby authorize any outstanding balances not covered by my insurance carrier to be automatically applied to:

Credit Card (circle one): Visa MasterCard American Express

Card #: _____ Expiry Date: _____ (mm/yr) CVV: _____

Name (on credit card): _____

Signature of Cardholder: _____