

**EAST TAYLOR DENTAL, P.C.**  
**OFFICE POLICY**  
**Killian J. Horner, D.D.S.**

*Welcome to our practice! We are dedicated to performing high quality dental care using the latest dental technology advancements in a caring and friendly environment; providing our patients with a uniquely positive dental experience. We thank you for choosing to be a part of our dental practice and welcome your referrals of family and friends.*

We are concerned about the cost of your dental care and want to address some current issues related to the cost of dental services. Considerable care has been taken in setting our fees. Every effort has been made to insure that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Please take a moment to review our policies. Please ask all questions before signing. Thank you.

#### **APPOINTMENTS**

- ❖ Once an appointment is made, please remember this time is reserved specifically for you.
- ❖ If you must change your appointment time, East Taylor Dental, P.C. requires a forty-eight (48) hour, (at least 2 full business days) notice on any cancellation or re-scheduled appointment. (Legitimate emergencies are an exception.)
- ❖ We reserve the right to assess a fee for the time reserved for an appointment in which a 2 business day's cancellation notice is not given, as stated above. This fee can range from a minimum of \$25.00 to \$125.00/half hour, based on the complexity of services to be performed at your time of visit.
- ❖ Cancellation or appointment changes must be handled by a staff member and not via our voicemail system.

#### **INSURANCE**

- ❖ If you have dental insurance coverage, East Taylor Dental, P.C. will file your dental claims as a courtesy to you.
- ❖ Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party and the Patient/Responsible Party is personally responsible for payment of fees.
- ❖ We DO NOT render our services on basis that insurance companies will pay all of our fees.
- ❖ All patient co-payments and deductibles, as required by your specific insurance coverage, are due and payable at the time of EACH visit.
- ❖ You are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeated filing of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to a re-filing fee of \$10.00 per claim.
- ❖ If payment for your claim has not been received within 45 days from the time when the claim was filed to your insurance company, you, the Patient/Responsible Party, will be responsible for any unpaid balance.
- ❖ If your insurance company pays less than the estimated benefit, you will be responsible for the remaining balance.
- ❖ If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. Per your request, you may leave the credit on your account for future care or you may request a refund. East Taylor Dental, P.C. will make every effort to process refunds within five (5) business days from the date the request is received. Please keep your personal information up to date, as a verifiable address must be available for us to mail checks.

- ❖ East Taylor Dental, P.C. will make every effort to minimize bookkeeping errors. In the event that an error should occur, we will do our best to refund any credits as stated above. Should the error result in a debt owed to us, we will provide a corrected statement and will allow forty-five (45) days for payment to be rendered in full.

#### **PAYMENT AGREEMENT**

- ❖ For and in consideration of the provision of services, I accept the fee charged as a lawful debt and promise to pay said fee in full for all services at the time services are rendered.
- ❖ We accept cash, personal checks, MasterCard, Visa, American Express, or Discover Card. We do not accept post-dated checks.
- ❖ Extended payment plans and interest free financing plans are available through Care Credit, Chase Health Advance and Springstone Financing.
- ❖ In the event payment is not received by the agreed upon dates, I understand a 1 ½% charge (18% APR) will be added to my account and my account is subject to a \$10.00 rebilling fee per each monthly statement.

#### **COLLECTIONS**

- ❖ East Taylor Dental, P.C. reserves the right to assess a service charge of \$30.00 for all returned checks. (Or the maximum allowed by law.)
- ❖ East Taylor Dental, P.C. also reserves the right to forward any and all accounts over 90 days past due to an outside collections agency.
- ❖ I agree to pay any cost accrued in the collection of my account, including the cost of the collection agency (33.33% of overdue balance), reasonable attorney fees and court costs, if such should be necessary.
- ❖ I authorize any employee or Agent of East Taylor Dental, P.C. to contact me at any number(s), (including my cell phone) for the purpose of treatment, insurance or payment for service rendered.
- ❖ I waive all rights of exemption under the Constitution and laws of the State Alabama.
- ❖ I further authorize East Taylor Dental, P.C. to receive and exchange credit information.

*I hereby authorize release of medical information for insurance claims and payment of my group insurance benefits, otherwise payable to me, to the dentist. I further agree to accept and adhere to the above office policy of East Taylor Dental.*

**PATIENT, PARENT, OR GUARDIAN SIGNATURE:**

**DATE**