Welcome to our office:

We highly suggest you read the following *before* signing as it outlines our office policies.

ALL PAYMENT IS DUE AT THE TIME OF SERVICE. Our office will file your primary insurance as a courtesy to you, but it is customary for your portion to be due the date services are rendered. Payment plans are available through Care Credit and we accept cash, check, Visa, Master Card, and Discover.

A $75 FEE WILL BE CHARGED FOR ANY BROKEN APPOINTMENTS SCHEDULED MONDAY-FRIDAY WITH LESS THAN 48 HOURS NOTICE. ANY BROKEN APPOINTMENT SCHEDULED ON A SATURDAY WILL RESULT IN A $200 FEE WITH LESS THAN 48 HOURS NOTICE. Please note, failure to take needed medications before dental appointments or not having payment at time of service will result in the fee of our Broken Appointments.

A SERVICE CHARGE OF $25 IS APPLIED FOR ANY RETURNED CHECKS.

Our practice believes in the importance of quality dental care, and we strive to provide the best dental treatment possible. Also, we understand the financial limitations that influence your choice of care. We want to assure you of a flexible approach to financing.

Please, remember, however that **you are responsible for the portion of your treatment not covered by your insurance**. Our insurance department verifies insurance as a courtesy for our patients, but **our office cannot guarantee payment from your insurance**. We do highly suggest patients to personally contact their own insurance carriers to verify coverage. We, to, must balance our finances, thus why we ask you to pay your portion at the time of treatment. For your knowledge, our three locations have separate statements and accounting as they are three separate locations. You are responsible for making payments to each individual office if seen at multiple locations.

We hope that you find this information useful. Rest assured that we are here to help make quality dental care obtainable for all. We look forward to working with you to achieve excellent dental health.

Thank you for choosing our office!

-Lakemoor Dental

____ DATE: ________________

(PATIENT NAME PRINTED)

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(PATIENT/RESPONSIBLE PARTY SIGNATURE)