

OFFICE POLICY

As a courtesy to you we will file your insurance. However, we cannot guarantee your insurance will pay as estimated. The final account balance remains your responsibility.

The insurance company's responsibility is to the insured (patient) not the provider (dentist) for professional services. You are responsible for providing us with all insurance policy information enabling us to submit your claims efficiently and accurately. You are responsible for supplying us with a claim form when necessary.

The following charges may also be incurred:

1. A minimum charge of \$35.00 will be made for any check returned.
2. A minimum charge of \$35.00 will be made for appointments cancelled less than 24 hours in advance of the scheduled appointment or if you don't show up for a scheduled appointment. Any subsequent appointments missed or cancelled less than 24 hours in advance will be charged \$45.00.
3. A \$5.00 charge per month will be charged on accounts due over 60 days.
4. A charge will be added to your account if further collection and/or legal action is necessary to collect fees owed to Nancy A. Barnett.
5. If there is a Payment Plan, but you miss an installment then an additional \$25.00 per month will be added to the account.

I understand that I am responsible for all charges incurred. I authorize Nancy A. Barnett, D.D.S., M.S. to act as an agent in helping me obtain payment from my insurance carrier. I authorized payment directly to Nancy A. Barnett, D.D.S., M.S.

I authorized the Dentist or her employees to release any information required in the course of examination or treatment and permit payment directly to her for any services rendered. I recognize and accept responsibility for all charges whether or not covered by insurance within 60 days.

I have read and understand the above policies.

Signature of patient/parent or guardian if patient is a minor;

Signature

Date