

Practice Policies

Thank you for choosing our office to meet your dental health care needs. It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. In order to keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines:

Payment Options

To provide you with the best possible care, we require you to pay your co-payment at the time of service. Please understand that payment of your bill at the time of services is considered part of your treatment.

As a courtesy, we will file your dental insurance for you and wait for the estimated insurance payment. It becomes the patient's responsibility to cover procedures that are not covered by his or her insurance plan. Please note, not all services may be covered by your insurance carrier and every insurance carrier and every insurance plan has its own unique "quirks" and exceptions.

We hope this information adequately explains the options available to you. In the space provided below, please indicate the method of payment you plan to use:

- Cash, Check, or Money Order
- Visa/MasterCard/Discover/American Express

Extended payment option:

- Dental Fee Plan (A line of credit for your dental treatment)

Cancellation Policy

There are many times when our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the office advanced notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way, the office can best serve the needs of ALL patients.

Bearing these special needs in mind, the office requires a minimum of 24 hours notice if an appointment must be cancelled. If less than 24 hours has been given to cancel an appointment, a \$50.00 fee will be assessed. In the event that no notice is given and the patient does not show up for their scheduled appointment, a \$75.00 will be assessed. Please note that this fee is not covered by dental insurance and payment is the patients' responsibility.

We at Gateway Dental welcome you to our "family" and look forward to taking care of your oral health needs.

Authorizing Signature: _____

Date: _____

Print Name: _____