ULTRA SMILE

Office Financial & Insurance Policy

We want to make your visit productive and enjoyable. We are happy to answer any and all of your questions regarding insurance plans and payment policies.

Our office Policy requires that payment be made at the time of service for your visit unless other arrangements have been made with the financial coordinator.

- To assist you with your payment, our office accepts Visa, MasterCard, Care Care Credit and Sunbit Financing.
- Personal checks are accepted with copy of a valid driver license.
- There will be a $35.00 penalty fee for all returned checks.

When your bill is unpaid, usually due to no payment from insurance companies, a collection agency may be appointed to manage the delinquent account if the account remains unpaid. If your account is placed with a collection agency, you will be responsible for all costs of collections.

Appointment and Cancellation Policy

- Appointments made for **more than 1-2 hours** may require a deposit that will be deducted from the bill for that visit. Deposit amount varies. If appointment is cancelled without a previous notification,, the deposit may not be refunded.
- We require a **48-hour cancellation notice** for any scheduled appointment.
- Patients who fail to show for their scheduled appointment without giving due notice will be charged a **$30.00 broken appointment fee** which is not payable by your insurance company.
- If you are late 15 minutes or more for your appointment, you are automatically cancelled.

Insurance claims for your carriers are filed as a courtesy at no charge to you. If you are a member of a Dental Insurance Plan and have chosen us as a provider for your care, it is your responsibility to:

- Provide us with the information related to your claim, including insurance card number, employer, and birth date, address and social security number. This information is requested on the patient health history form, which we ask that you complete during your initial visit.
- Pay your deductible or co-payment at time of service.
- Pay for services not covered by your insurance carrier.

Authorization & Release:

I authorize **Ultra Smile Dentistry** to perform the necessary dental services for my diagnosis, treatment and to receive payments from my insurance company, if applicable. **Ultra Smile Dentistry** may file the necessary form to receive full benefits of coverage. **However**, this office **cannot guarantee** any estimated coverage. My insurance is an agreement between my insurance company and myself. **I am responsible for all charges.**

I have read and fully understand my financial responsibilities under this policy.

PATIENT/GUARANTOR SIGNATURE

DATE