MARION DENTAL GROUP

James E. Edwards, D.D.S. Thomas K. Bailey, D.M.D. Kevin B. Wallace, D.M.D.
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Insurance & Payment Policy

Insurance is an agreement between you and your insurance company. Insurance coverage is only an estimate. Lack of payment from an insurance company does not negate the patient's responsibility to pay for services rendered in good faith. Consequently, if a claim is denied or short paid by an insurer, the cost of treatment ultimately remains the patient's responsibility. ****I also understand that my estimated out of pocket is due at the time of service unless prior arrangements have been made. I understand payment is expected at time of service unless you agree to file my insurance.**** If, however, after 90 days my insurance has not paid my claim, I understand and agree to pay my balance in full for services rendered to me. **I understand if my account is placed for collections, a fee of 35% of the balance due or 5% interest will be added to my account, whichever is greater.** I authorize Marion Dental Group to contact me at home or at work to discuss any matter related to this form or any dental treatment. **I have read the conditions stated relating to treatment and payment, and agree to their content.**

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(Initials)

Broken Appointment Policy

A broken (missed) dental appointment presents problems for everyone. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health. For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient deserves.

We understand situations may arise that will prevent you from keeping your appointment, but we ask that you kindly give us advanced notice of **24 hours** so that we may fill your appointment time. **If you miss an appointment or fail to give us the proper notice, we may enforce our "Broken Appointment Policy" which states you will have to pay $25.00 PRIOR to rescheduling your appointment.**

_____ _____/_____/_____
Patient (or Parent/Guardian) Signature **Date**