# Corley Family Dental Office Policies

Thank you for choosing Corley Family Dental as your dental provider. We pride ourselves on providing all patients with excellent dental services. Billing costs have risen enormously and we ask your help in controlling these costs. To keep you informed of our current financial policies, please read the following, initial each policy, and sign at the bottom. Let us know if you would like a copy made for your future reference.

**Office Hours**

Mon 7am-7pm; Tues & Wed 7am-5pm; Thurs 7am-4pm; Fri 7am-4pm; Sat 7am-noon (2x month)

**Missed Appointments: _____INITIAL**

We request the courtesy of a 24hr notice when cancelling so that we can contact another patient who needs our care.

A **fee of $50** will be assessed per scheduled appointment for **Saturday appointments** and **4pm, 5pm and 6pm appointments.**

A **fee of $40** will be assessed per scheduled appointment for other times.

**Copays, Deductibles and Non-Covered Services: _____INITIAL**

All estimated co-pays, deductibles, and non-covered services are **due at the time of service**. We accept cash, check, credit cards, and care credit. These charges cannot be waived by our practice, as they are a requirement placed on you by your insurance carrier. You are responsible for any non-covered services as determined by your insurance plan. Although we file claims for most insurance plans on your behalf, you are ultimately responsible for payment of the bill.

**Past Due Balances: _____ INITIAL**

You will be asked to pay any past due balances when making appointments or before seeing the dentist. Any account that has an unpaid balance after 60 days will be applied a 2% monthly service charge.

**Returned Checks: _____ INITIAL**

There will be a $35.00 charge added to your account for any check returned by your bank.

**Collection Policy: _____ INITIAL**

All efforts will be made to work with our patients on outstanding balances. If an account must be sent to collections and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance.

**PATIENT NAME _____ SIGNATURE_____ DATE_____**