OFFICE POLICIES

Appointment and Cancellations

Patients are seen by appointment during office hours. We reserve that time for you and your specific dental needs only and appreciate as much advanced notice as possible if you cannot make your appointment, so that we may schedule another patient at that time. Our staff will place a courtesy call to you 24-48 hours prior to your appointment to reconfirm the appointment time with us. In the event that we are unable to reach you, it is considered your responsibility to keep your scheduled appointment. If you should fail to show for your appointment without 24 hour notice of cancellation, you may be charged at minimum $25. The charge may be increase depending on the appointment type and length.

Your prompt arrival is also greatly appreciated, and we do our best to stay on schedule by operating in an efficient manner. In the event of a patient emergency, we may need to deliver extra attention to them to make them comfortable. We appreciate your understanding in these situations; be assured that we will provide the same consideration to you if an emergency arises. We will attempt to contact you prior to your appointment if an emergency situation arises and we may be delayed. Please feel confident that you will receive our utmost attention and excellence of care when we do see you.

Emergency Care

Our goal at Crossbridge Dental is to provide comprehensive dental care and detect any dental problem before it becomes an emergency. However, our office is prepared to handle unexpected problems. We ask that you call the office as early in the morning as possible so that we may see you as soon as possible. If you experience a true dental emergency AFTER HOURS, please call the office and the message will instruct you on how to contact the doctor.

Insurance

We participate in several insurance plans and our office is committed to helping you maximize your benefits. If we participate with your insurance, we will submit a claim on your behalf. You are responsible for any copayments or non-covered services under your dental insurance policy. Because insurance companies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage even with a written estimate of benefits from your insurance carrier due to the complexities of insurance contracts. Your estimated copayment is due at the time the services are rendered.. If you do not have insurance, full payment is expected at the time of service unless other arrangements are previously made.

Payment

We are dedicated to making top-quality dental care as cost effective as possible. To assist you with your health care investment, we provide the following payment options:

- Cash, Money orders or Personal checks (please be aware there is a $35 fee for any returned checks)
- Visa, Mastercard and Discover cards
- Care Credit Financing for treatment plans totaling over $300-please note this is a third party financing line of credit for which you must qualify. There are multiple plans including little or no interest for up to three months.

We are happy to provide these options for you. You can decide which option works best for you at your initial visit.

Full payment is expected at the time of your service unless prior arrangements have been made. In the event that payment is not made by the due date, a late charge and/or rebilling fee may be added to your account. Any balance that is more than 30 days outstanding is subject to a 1.5% monthly finance charge. Any outstanding balance over 90 days may be sent to a collections agency for further action. If this should happen, any collection fees (including attorney's fees and continued accrued interest) incurred on the account our by our office in an attempt to obtain payment will be the responsibility of the account guarantor.

I, ____ certify that I have read and do hereby agree to the above stated office policies of Crossbridge Dental, P.C., Dr. Gretchen M. Palmer or associates thereof.

Guarantor Signature: ____ Date: _________________________________

Parent or Responsible Party: ____ Relationship to Patient: ___________________________