



## WELCOME TO RAILWAY AVENUE DENTAL!

Thank you for selecting us as your personal dental team. We are very proud of our knowledgeable, well trained, and caring dental team. You will find us dedicated to maintaining optimum oral health.

### **Please take a minute to familiarize yourself with some of our office procedures and policies.**

- Every effort is made to provide adequate notice for upcoming appointments, and confirmation responses. If you are unable to keep your appointments, and changes are required, please **DO NOT** use email, or a text message to cancel or reschedule your appointment. We require you speak directly to one of our treatment co-coordinators in order to accommodate your request, **as we are unable to accept or respond to these types of scheduling changes via e-mail or text message.**
- No charge will be made for rescheduling an appointment, providing 2 working days notice is given; otherwise a charge will be incurred. Once an appointment has been made, please remember that this time is reserved specifically for you.
- Dental Insurance is a contract between you and your insurance company. As a courtesy, we will accept assignment on your behalf and/ or prepare and submit a predetermination if required. Because of the privacy act we are not privy to the terms and restrictions of your plan (ie. yearly maximum and benefit year, recall frequency, units of scale), therefore you are responsible for any money owing which your dental plan does not cover.
- In order to accept assignment from your dental plan, we require an imprint and signature of a current and valid credit card. Payment is required at time of service for any amount not covered by your plan. If we do not know your balance the day you are in for your dental services we will utilize your credit card once we receive payment from the insurance provider. As a courtesy, If the amount is over \$100 we will notify you. Either way you will receive a receipt by mail or email.
- Assignment is not accepted with regards to specialty services; ie: orthodontic treatment, dental implants.

### **Your Financial Consent**

The patient/or guardian agrees to be fully responsible for total payment of procedures performed in this office for any treatment NOT covered by the dental insurance.

I certify I have read and understood the above.

Today's Date: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Sign: \_\_\_\_\_ Print: \_\_\_\_\_