Cary Periodontics and Implant Dentistry
Scheduling and Financial Policies

Scheduling and Cancellations

Cary Periodontics and Implant Dentistry will make every effort to accommodate the scheduling needs of our patients. In doing so, we attempt to promptly reschedule the patient's treatment if the need arises. Failed appointments, however, greatly impact the practice's ability to meet the needs and expectations of patients awaiting treatment at the practice. Therefore, the patient agrees to inform our office of any desired appointment change by the appointment time on the prior business day. We are closed most Mondays, so Tuesday appointments must be rescheduled no later than the appointed time on the prior Friday. The patient also understands that multiple failed appointments may result in appointment fees or possible dismissal from the practice. The practice considers failed appointments to be:

- Cancelling the day of their scheduled appointment time (i.e. less than 24 hours)
- Failing to arrive at the office for the appointment ("no-show")
- Arriving to their appointment so late that they unable to be seen due to schedule conflict

Finances

Full payment for treatment is due at the time of service. For patients electing oral or intravenous sedation, payment may be requested up to two (2) business days prior to the date of service. Our office gladly accepts Visa, MasterCard, Discover, American Express, cash, check, and a payment plan through Care Credit. If you would like to arrange for Care Credit payment options, please consult our front office staff. A processing fee of 3% will be assessed for any returned credit card transaction.

As a courtesy to our patients with dental insurance, we are happy to file your dental insurance claim for services provided. When a pre-treatment estimate of coverage is obtained from your insurance company, we accept assignment of benefits for the estimated amount due from your insurance plan. Please understand that any estimate given by your insurance company is only an estimate and not a guarantee of insurance coverage. Please read carefully the correspondence from your insurance company. Insurance companies often have their own schedule of what they consider "Usual and Customary" (UCR) fees. These fees can vary greatly among different plans. Please understand that your insurance is an agreement between you, your employer, and your insurance carrier. Our practice is not a party to that agreement. Therefore, please understand that you are ultimately responsible for payment for treatment received from the practice.

For patients with Medicare, Cary Periodontics and Implant Dentistry does not participate in the Medicare system. Because almost all dental procedures performed at our office are not covered under Medicare, we have signed an opt-out agreement with the Medicare program. As part of this agreement, both our practice and our patients cannot submit a Medicare claim for services provided by our doctors. Since no Medicare benefit can be received, the patient is responsible for paying the practice directly for services provided.

With regards to treatment of minors, whoever brings the child to the appointment is responsible for the payment due. Our practice does not get involved with any custody and financial agreements you may have with other responsible parties. Please inform and ensure that the person bringing the minor is prepared to make full payment.

Dentistry is not an exact science and at times unforeseen clinical situations may arise during treatment that may reflect additional charges. We also realize that occasionally unforeseen circumstances may affect payment arrangements. Should this happen, please promptly notify our office manager so that suitable arrangements can be made. A 1.5% monthly (18% annual) service charge may be added on all accounts over 90 days.

Acknowledgment

I realize that I am ultimately responsible for the charges for any treatment received from the practice, even if my insurance carrier pays nothing. I further understand that I will be responsible for any fees associated with collections of any unpaid balance. I have read, understand, and agree to the above scheduling and financial policies.

Patient Name: _____

Patient's Signature:_____ Date: _____

Responsible Party/Guardian:_____ Relationship:_____