Atkins Dentistry Office Policies

Fee for Service

Atkins Dentistry is a fee for service office. Payment is due and collected at the time that service is rendered. If a patient has Dental insurance, the fee collected will be the estimated portion of the Patients Responsibility (Co-Insurance), including any deductibles and/or co-pays. Atkins Dentistry currently accepts; Checks, Cash, Major Credit Cards and Care Credit. A financial agreement may be discussed.

Failed/No show/late appointment policy

Your appointment times are reserved especially for you. When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. If you are unable to keep your appointment, please notify us at least **24 hours** prior to your appointment time. As a courtesy to you, we will attempt to confirm your appointment, but it is your (or guardians) sole responsibility to keep and confirm scheduled appointments. Please feel free to opt into our automated service which will send a save the date, a 4-day reminder and a day of reminder via text, email or phone. Any **Failed appointments, with less than 24 hours' notice will be subject to a Failed appoint Fee. A fee of $50.00 will be assessed for a Failed Hygiene appointment. A fee of $150.00 will be assessed for a Failed restorative appointment with the Dentist.**

Insurance Information

Insurance is filed as a courtesy to our patients. Atkins Dentistry will make every attempt to file claims on the patient's behalf but *cannot* guarantee cooperation from the insurance company. In the case that we are unable to receive payment, the assigned responsible party, will be required to pay any, and all remaining balances of services provided.

There is no direct relationship between Atkins Dentistry and your insurance company. The types of plans chosen by you and/or your employer will determine your insurance benefits; Dental insurance policies vary. While it is your responsibility to understand your insurance policy, we will do what we can to help you understand and maximize your insurance benefits.

Atkins Dentistry will accept payment directly from your primary insurance company in most cases. Prior to treatment, Atkins Dentistry may attempt to contact your insurance company to estimate/pre-determine available benefits. This will inform our office what your insurance company is estimating to cover. This will only be an estimate of benefits and not a guarantee of payment. We suggest that you contact your insurance company to verify benefits as well. You or the assigned responsible party will be responsible for payment of the balance not covered by your primary insurance (your estimated portion) at the time of treatment. If finance arrangements for the patients; portion for the fee are necessary, they must be arranged prior to treatment.

Insurance/communication authorization/scope of care

I authorize the release of any information obtained in my dental files for the purpose of treatment, billing and processing of insurance claims. I permit a copy of this signature if needed, to be used in place of original on all my insurance submissions. In addition, I authorize release of any information contained in my dental files to the referring dentist(s) and/or treating dentists and/or physician(s). Also, I authorized my medical physician to release any or all information/lab work that is pertinent to my dental treatment with Atkins Dentistry.

Overdue/unpaid accounts will be subjected to collections.

After 45 days, any unpaid balance not covered by insurance company will be billed to you and due within 15 days. Overdue accounts (balance due over 60 days) may be subject to finance charges of 1.5% monthly (18% annually) or sent to collections after 90 days. The patient or assigned responsible party will be responsible all associated fees incurred by Atkins Dentistry

Returned Check Fee

A fee of $35.00 along with any additional fees assessed by Atkins Dentistry's financial institution may be charged for insufficient funds/returned checks. After examination an initial treatment plan will be established and fees will be reviewed. During treatment, unexpected situations may be discovered. The actual fee(s) charged will be dependent on services rendered in order to correct periodontal/other destruction/damage/disease.

I understand and agree to these office guidelines as stated above.

Signature of Patient or Guardian/Responsible Party:

X_____ Date_____ Revised 01/2022