Benjamin D. Bushnell, D.D.S.

FINANCIAL RESPONSIBILITY

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your questions and/or assist you in any way we can.

All dental services, including emergencies, must be paid in full at the time services are performed unless other arrangements are made.

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. **As such, we can make no guarantee of estimated coverage or payment**. However, please know that we will do everything possible to see that you receive the full benefits of your policy.
Please be advised that any remaining balance after insurance has paid will be your responsibility and you will be expected to pay the estimated balance at the time services are performed. You are ultimately responsible for all charges incurred for dentistry performed upon yourself or your dependents in this dental office. This office cannot render services on the assumption that our charges will be paid by an insurance company. Any insurance claim not paid in full after 60 days will become your responsibility to pay at that time.

I authorize Benjamin D. Bushnell D.D.S. to perform dental procedures on me, my minor children and / or family members. I understand that dental procedures may vary from planned treatment at the decision of the dentist, according to his knowledge or judgment, in order to provide the highest quality of care in the best interest of the patient.

I hereby authorize the release of any information, including any diagnostic records (x-rays, photographs, charting) to my insurance company. I authorize my insurance company to pay directly to Benjamin D. Bushnell D.D.S. any proceeds payable under the terms of my insurance policy. I understand that I am responsible for my dental bills and the balance on my account regardless of my insurance coverage. I understand that I may incur an 18% finance charge if my balance goes beyond 30 days. I understand that I may incur a $25 charge on returned checks. I understand, in the event that my account is turned over to an outside collection agency that I am responsible for all fees incurred by Benjamin D. Bushnell D.D.S., P.C. as a result of nonpayment on my account. I hereby authorize the use of the telephone numbers that I have provided for clinical and collective purposes. I have read and understand the financial policy statement provided to me by office staff.

CANCELLATION POLICY

We respect the importance of your time and work very had to schedule appointments which accommodate the needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice.

If emergency circumstances prevent you from keeping an appointment, we ask that you call us immediately so we can try to accommodate another patient. Please provide us with a minimum of 24 hours notice of cancellation. Failure to do so may result in a cancellation/missed appointment fee.

We provide, as a courtesy, reminder cards that are mailed for dental hygiene appointments. We also make reminder calls to our patients 48 hours prior to an appointment. This effort shows our commitment to all of our patients and the importance of their health.

I have read and fully understand the above office policies regarding payments and cancellations and accept the terms as they were presented to me.

Print Name_____ Date_____

Signature_____