

  
**Shelton DENTAL CENTER**  
**Patient Policies**

**Notice of Privacy Practices:** We keep a copy of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will NOT disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about how your health information may be used and disclosed by contacting our patient coordinator.

*By my signature below I acknowledge receipt of the Notice of Privacy Practices.*

\_\_\_\_\_  
*Signature of Patient or legally authorized individual*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Relationship to patient (if not self)*

**Cancellation, Late, or Missed appointment Policy:** We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your oral health is something our office takes quite seriously. Because we care about you we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the policies we ask you to adhere to.

*We want to see you on time to have adequate time to do the necessary procedures. Arriving on time will permit all the treatment planned for the day. All appointments should be made before leaving the office, when possible, as our schedules fill quickly.*

*We expect you to keep all your appointments. With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Patient Coordinator.*

*In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a \$50.00 fee. In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care, allow care on a space available basis, or provide appointments on a pre-pay basis.*

*We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.*

*Continued on back*

**Financial Policy:** We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget.

**Dental Insurance:** We welcome an open discussion of services and fees prior to treatment in order to avoid any kind of misunderstanding. Once insurance eligibility is determined, as a courtesy to you, we will file for payment of your benefits. We ask that your estimated co-payment and deductible be paid at the time of your service. We accept cash, checks, debit and credit cards. Dental Insurance has limitations that we, as your dental provider, do not control. It is important to keep your account with our office up-to-date, regardless of the payment schedule of your insurance company. Ultimately, your bill is your responsibility.

**Optional Payment Terms:**

1. **Full Pre-Pay Cash Courtesy:** We offer a 10% courtesy for all treatment that is paid in full by cash or check five working days prior to the day that treatment is begun. For credit cards the courtesy is 7%. If you have dental insurance, paid-in-full will mean you will receive the courtesy discount on the estimated co-pay portion.
2. **Full Pay Cash Courtesy on Day of Service:** We offer a 5% courtesy for all treatment that is paid in full by cash or check on the day of treatment. There is no day of service courtesy for credit cards. If you have dental insurance, paid-in-full will mean you will receive the courtesy discount on the estimated co-pay portion.
3. **Major Service – Two Payment Option:** We offer a two-payment option for crowns, bridges, root canals, and denture treatments. We ask that you pay one half of your treatment cost at the first appointment and the second half at the second appointment.
4. **Credit Card Payment Option:** We allow (with a signed agreement form and established payment history), a Credit Card Payment Option which allows you to make three equal installments by credit card. One-third of treatment cost is charged to your credit card at the first appointment; one-third is charged to your credit card 30 days later; and the final one-third is charged to your credit card at 60 days from the initial appointment. Our office personnel will bill these to your credit card on the due dates.
5. **Out of Office Financing:** By arrangement with CareCredit and/or CitiHealth Card, we offer our patients, upon approval, an interest-free, low monthly payment plan option through these third parties with no down payment, no annual fee, and no pre-payment penalty. Please ask for a hassle-free application with an on-line decision in minutes.

**Payment Policies:** There is a \$25.00 fee on all returned checks. Accounts 30 days past due will accrue a 1.5% per month late payment charge on any amount over-due.

By my signature below I acknowledge receipt of the appointment and financial policies.

\_\_\_\_\_  
Signature of Patient or legally authorized individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient (if not self)