Sensational Smiles

Patient Guide

Whether you are new to our practice or we have had the pleasure of serving you over the years we would like you to be aware of our office policies. Our mission is for you to have a sensational smile that will last you a lifetime because you deserve it. The treatment we recommend and provide is conducive to that goal. We use only the latest technology and the best of materials and we strive to make high quality dental care affordable to all of our patients. If you ever have any questions or concerns regarding treatment and/or your financial investment we believe that clear communication is the best pathway to achieving your goals.

Financial options:

We want all patients to feel comfortable with the investment they are making in their oral health. Below are our payment options, please choose the one that works best for you. **Payment is expected the day services are performed**.

 Cash, personal check, or Visa/Mastercard/Discover. NSF $35.00

 Payment by appointment (total fee /# of appointments=payment due at each appointment.)

 Payment Plans through our partner financing companies CareCredit and CitiHealth (up to 12 months no interest with approved credit.)

Patients with dental insurance:

As a courtesy to you, we will gladly process insurance claims to your dental insurance carrier. We do not file medical insurance or Medicare. We are a premier preferred provider for all Delta Dental plans. Our responsibility is to provide you with the treatment that best meets your needs, not try to match your dental care to an insurance plans' limitations. Dental insurance plans do not correspond to individual patient needs, and as such many preventative, routine, and necessary dental services are not covered even though you may need those services.

 For any procedure, if you have a concern about coverage please contact your insurance carrier with the dental coding and our fee. We make an initial call to your dental insurance to make certain of eligibility and get a breakdown of coverage. With this limited information **we are able to determine your estimated co-payment for services but cannot be held responsible to that estimate in any way**. We will collect all co-payments and deductibles the day services are performed.

 You agree that you are responsible for all charges regardless of insurance coverage.

 Your dental insurance is a contract between you, your employer and the insurer. We are not a party to this contract. Please review your policy booklet for annual individual maximums, limitations and clauses your plan may contain. It is your responsibility to be aware and provide this information.

 If your account ever results in a credit over $100 a refund check will be issued immediately. If under $100 we will put the credit towards future services unless you request otherwise.

Minors:

The adult accompanying the minor is responsible for total charges. For unaccompanied minors, treatment will be denied, unless treatment and charges have been preauthorized from the parent or legal guardian.

Cancellation or Re-Scheduling:

Your dental health is our main objective. Therefore, it is extremely important for you to keep all of your scheduled appointments. We understand that emergency situations do arise that may require you to change an appointment. **As a courtesy to other patient and our office, we ask that you kindly provide us with a minimum of 24 hours notice (weekends not included).** We would prefer a phone call during business hours if you should need to change/cancel your appointment. This courtesy on your part will make it possible to give the reserved time to another patient who needs to see the dentist or the hygienist.

Radiographs (X-rays):

If you have current x-rays from a previous dentist, it is your responsibility to have those sent to our office prior to your appointment. If you do not notify us that you have current films/digital x-rays, we will take new ones. Insurance companies have limitations on how often they will pay for x-rays. Therefore it is important that you notify us that you have had recent x-rays.

Emergency Visits:

First office visits that are **Emergency** visits -- full payment will be expected regardless of insurance coverage.

Past Due Accounts:

You understand that you are financially responsible for all total charges incurred by yourself and/or your dependents. A monthly interest rate of 1.5% (APR 18%) will be incurred for accounts (60) days past due.

In the event that your account is past due (90) days from the date of service, it will be turned over to a collections agency unless formal arrangements are made in advance. You understand that you are responsible for any collections, legal fees, and any other charges incurred to collect this account.

Authority to Treat:

You give the dentists of Sensational Smiles the authority to administer dental x-rays, local injections, and nitrous oxide (if applies) prior to your treatment. You understand that you will receive a treatment plan for the doctor's diagnosis and that any treatment diagnosed is recommended to be done in a timely fashion. If treatment is delayed, the diagnosis may lead to a more difficult, costly and/or compromised treatment solution. During any procedure, unknown circumstances can arise which would alter treatment and costs. Any changes in your treatment plan will be discussed with you. Procedure fees are valid for 90 days after initial diagnosis. **Please advise the doctor or hygienist of ANY and ALL medications (including pre-medications) that you may be taking before services are started.**

Insurance Signature Authorization:

You authorize the release of any information including the diagnosis and the records of any treatment or evaluation rendered to yourself and/or your dependents by any licensed health practitioner relating to all claims for benefits submitted on behalf of yourself and/or your dependents. You agree and acknowledge that your signature on this document authorizes Sensational Smiles to submit claims for benefits, for services rendered, and for services to be rendered, without obtaining your signature on each and every claim submitted for yourself and your dependents. You will be bound by this signature as though you had personally signed each claim. You hereby assign all dental benefits to which you are entitled, for services performed in this office, to Sensational Smiles. A photocopy of this assignment is to be considered as valid as an original.

Release of Medical Information:

You hereby authorize Sensational Smiles to release copies of any health records to any licensed physician, medical practitioner, hospital, clinic, or other medical or medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any record or knowledge of yourself and/or your dependents. A photographic copy of this authorization shall be as valid as the original.

I have read, understand, and agree to the above patient guidance's.

Patient Name (Printed): _____ _____ Date:_____

Patient Signature (Parent or Legal Guardian if patient is a minor)

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