OFFICE POLICIES

Cancellation/Broken Appointment and Late Arrival Policy

At Oakwood Dental Arts our providers are committed to providing quality care; we ask that you please be respectful of the time that is scheduled for your appointment(s). Our policy requires that you give us, at minimum, 24 hours notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. Failure to do so will result in a $25.00 fee for your broken appointment. If you arrive 15 minutes (or more) late for your appointment, you may be asked to reschedule. Please make every effort to arrive at the given check-in time to avoid any disruption in your care.
As a courtesy to our patients, we send texts/emails/postcard to confirm appointments. We also call two days prior to appointment, if the appointment has not already been confirmed via text/email. **Hygiene appointments in which we are unable to receive confirmation by 5pm the day before the appointment, 12pm by Saturday for appointments scheduled for Monday, will result in the cancellation of your appointment.**

Insurance Eligibility

As a courtesy to you, our patients, Oakwood Dental Arts will verify your insurance once, at the time of your initial visit. It is the responsibility of the patient to make sure that they, and all dependent family members, are eligible with their insurance on the date that services are rendered. Any insurance claims that are denied for any reason, other than an error of the office, have to be corrected within 30 days. If, after the 30 days have passed, the claims have not been corrected, the balance will become the responsibility of the member. The member will have an additional 10 days to submit remittance for this balance, or the collection process will begin.

Insurance Complaints

In the event that my insurance company does not comply with state and federal laws, I hereby authorize this office to file a complaint, on my behalf, to my insurance carrier, the appropriate State Insurance Commissioner as well as the National Association of Insurance Commissioners and/or The Division of Worker's Compensation.

Consent to Treatment

I understand all policies as listed above and hereby consent to diagnostic and medical treatment and/or examination.

Acknowledgement of Privacy Notice

I acknowledge receipt of the Notice of Privacy Practices from Oakwood Dental Arts.

_____ _____
Print Patient Name Signature Patient/Guardian

_____
Date

Oakwood
DENTAL ARTS

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to maintain optimal relationships between our staff and you, the patient, as well as to avoid any misunderstandings regarding our payment policies, we ask that you read and sign the following:

- The majority of insurance companies have some type of co-payment attached to certain services on their plan. These co-payments are the responsibility of the patient when the dental services have been rendered. For your convenience, we accept cash, check, all major credit cards, Care Credit, Citi Health, and Lending Club. You must have an agreed upon financial arrangement with the office.
- Any account with a balance over 30 days will be subject to an 18% interest charge. There is a 10 day grace period to pay your balance before your account incurs a monthly $15 late fee until balance is paid in full. Any checks returned for non-sufficient funds will result in an additional charge. I, the patient, agree to pay a reasonable attorney and/or collection agency fees in the event that my account is delinquent and requires the actions of either/both parties.
- If we participate with your insurance plan we will submit your claim for you, provided that you presented your insurance card at the time of your visit and that all personal information and eligibility is up to date. You are responsible for any patient liability included, but not limited to, co-pays, deductibles, and non-covered services under your plan.
- For the insurances we do not participate with, we will still submit the insurance claim on your behalf. We will direct the insurance company to reimburse you under the provisions of your dental policy, and note that you made a payment in full at the time of the treatment.
- Please understand that your insurance card is not a guarantee of payment, you are ultimately responsible to this practice for payment on all services. We will be happy to help you receive your maximum allowable benefits. However, please realize that the relationship is between you, the insured, and your insurance company. It is ultimately your responsibility to know the provisions of your plan. At this time we are unable to discount any services paid by insurance. Each plan has a contract with our office that states we MUST collect all copayments and deductible when treatment is rendered.

CREDIT CARD AUTHORIZATION

It is our office policy to obtain your credit card information and authorization to process a payment should your dental insurance not honor the claim submitted, or you have remaining out of pocket expense, or both. In providing credit card information below, you authorize payment by credit card services in the absence of coverage by your dental insurance (including but not limited to, copayments, deductibles, and/or non covered services), missed appointment fees, and/or bounced checks and associated bank fees. A phone call to the card holder listed below will be made prior to making a charge.

Name on Credit Card:_____ Billing Zip Code: _____

Credit Card Number: _____ CVV/CID _____ Exp Date:_____

Type of Card:_____ Signature: _____

_____
Initials of Patient
or Guardian