



Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices or been notified of its posting.

(Please print name)

(Signature)

(Date)

FINANCIAL POLICY

Michael Sanders, DMD

As a courtesy to you, we will file your insurance. Those portions of treatment or services that are not estimated to be covered by your insurance company (including patient co-pay and deductible) are expected to be paid at the time of service unless other arrangements have been agreed upon in writing. This office can make no guarantee of the insurance payment estimates. If, after 60 days, your insurance company has not paid the balance due on your account, you will be billed directly. Our staff makes every effort to maximize your dental insurance benefits and will gladly answer any questions you may have regarding this service. Ultimately, you are responsible for your account and knowledge of your insurance policy. Accounts remaining unpaid after 120 days may be turned over to collections. To assist you with financing, we accept Visa, Master Card and offer Care Credit, an independent financing program with various interest rates. Please ask our front desk personnel if you would like more information regarding this program.

Missed Appointments

No charge will be made for rescheduling an appointment provided at least 24 hours notice is given. We reserve the right to charge a minimum of \$75 for appointments broken or cancelled without this advance notice. Please remember your appointment time has been reserved specifically for you.

Returned Checks

There will be a \$25 handling fee for returned checks.

By signing below, I certify that I have read, understand and agree to this Financial Policy. Upon request, a copy of this Office Financial Policy will be provided to you.

Patient's Signature (parent or guardian if patient is a minor)

Date