BRENTWOOD FAMILY DENTAL
8083 Manchester Rd.
St. Louis, MO 63144

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice. We offer all of our patients the type of treatment and care that we, as dental professionals, would request or require on ourselves as well as our own family members. If you would like a different type of treatment than was offered, we would be happy to discuss alternatives.

Minimum office visit co-payment of less than $50 can be paid on the date of service. Office visit co-payments of more that $50 **have to be pre-paid before scheduling the appointment.**

PAYMENT OPTIONS

1. Cash or Check
2. We accept: MASTER CARD, VISA, AMERICAN EXPRESS and DISCOVER
3. Third-party financing such as CARE CREDIT or UNICORN (subject to credit approval)

We are happy to provide you with the above options to allow you to make convenient, low monthly payments. Applying for our third-party financing takes a few moments, however, if you choose one of the third-party financing options, you can begin any necessary treatment immediately and spread the payments out over time. We are happy to assist you in the approval process with third-party financing options but due to the high cost of offering this option we will charge a 5% handling fee for payments made with this option.

I understand that the dental service furnished to me by this office are charged directly to me and that I am personally responsible for payment of all dental services provided. If I carry dental insurance, I understand that this office will prepare and file all insurance claims associated with my visits on the date services were performed. However, if my insurance benefits are not paid within 60 days from the date of service, I understand I am responsible for payment in full at that time.

We file your insurance claim as a courtesy to you. Your insurance benefits are a contract between you and your insurance company. *For your own protection, it is essential that you familiarize yourself with your benefits.*

In the event that payments are not made and your account is forwarded to collections, there will be a fee of up to 35% for collection fee/attorney fee and or court costs applied to your account.

Signature of Patient/Responsible Party_____Date_____

APPOINTMENT CANCELLATION POLICY

We understand that unplanned issues can arise and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments and this appointments not cancelled within 24 hours.

Please initial each box to state that you have read and understand the policies.

☐ We require 24 hours notice to cancel an appointment.

☐ Appointments cancelled **WITHOUT** 24 hours notice will result in a $50/hr charge.

☐ Not showing for a scheduled appointment will result in a $50/hr charge and may result in dismissal from the practice.

Patient's Signature:_____ Date:_____

Print Name:_____