



## OFFICE POLICIES (REVISED 1-1-18)

*(Please initial all sections)*

**Cancellation Policy:** If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two business days' notice. This courtesy on your part will make it possible to give your appointment to another patient. Please note that after three failed or cancelled less than 2 business days' appointments, your account will be charged \$75.

**Treatment recommended by our providers is never based on what your insurance company will pay.** We request that you understand and are familiar with your benefit plan so that together we can make the best treatment decisions. If you have any questions about your coverage, we encourage you to call your insurance company to learn more about your coverage.

**Your insurance is a contract between you and your employer and the insurance company.** We are not a party to that contract. As a courtesy, we will assist you with information, however, if you have any additional questions about coverage, please contact your insurance company or human resources department.

**At the time of treatment, the patient/guarantor is responsible for the estimated portion that the insurance does not cover (also called "copay").** Our goal is to maximize your insurance benefits. Please remember that most dental insurance is not designed to cover 100% of the cost of all treatment.

**Brenner Dental Group bills insurance as a courtesy to our patients.** Regardless of whether we file your insurance claim, you are ultimately financially responsible for all services rendered. It is the patient/guarantor's responsibility to provide any new information regarding insurance.

**Payment Options and 3rd Party Financing/CareCredit:**

1. Payment In Full: cash, check, or credit (Visa, American Express, MasterCard, or DISC)
2. In House Payment Plans for copays/fees greater than \$200: 50% Down Payment + 25% monthly payment on a debit or credit card stored on file in office.
3. Care Credit: Deferred-Interest Monthly Payment Plans \*Subject to credit approval

**Returned Check Fee:** A fee of \$30.00 will be charged on all returned checks.

**Financial Policy:** I agree to pay fees and expenses incurred by Brenner Dental Group, PLLC to collect on this account. I understand that all balances 60 days and older are subject to interest at 1.5% monthly/18% annually. It is agreed and understood that if this obligation should become delinquent that I, the patient or guarantor party, agree to pay the collection costs and costs associated with placing my obligation to a collection agency and/or attorney for litigation and may result in dismissal from our office.

By signing this agreement, the patient agrees with the office of **Brenner Dental Group, PLLC** that any dispute relating to dental care services rendered for any conditions, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, shall be resolved by binding arbitration by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as the lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

**I have read and understand all of the information contained in this form,  
and sign on behalf of all members of this account.**

**Signature of PATIENT, PARENT, or GUARDIAN:** \_\_\_\_\_ **Date:** \_\_\_\_\_