LIGHT DENTAL
STUDIOS™

We appreciate the opportunity to serve you. Our intent is to provide you the finest care possible while ensuring that you fully understand our procedures, treatment and payment arrangements.

Payments: If you do not have insurance, please be prepared to fully cover the fees for each visit. Our office accepts cash, check, Visa, MasterCard and Discover.

Cancel Short Notice/No Show Policy: In an effort to keep cost down, understand that our office has a cancel short notice policy in place and that you are required to contact our office 48 hours in advance to cancel an appointment. If you neglect to do so, a fee of $25.00 per half hour of scheduled treatment can be assessed to your account.

Insurance: As a courtesy to our patients, we will submit charges to your dental insurance. Co-payments must be made prior to treatment. It is now unlawful for a doctor or office staff member to waive co-payments for any patient. (Health Insurance Portability and Accountability Act).

Please realize that professional services are rendered to the patient not the insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible directly to this office. We cannot render services on assumption that the charges will be paid by the insurance company. However, we will help in any way that we can.

Payment is due at the time of service. Once your insurance coverage has been verified, personal insurance accounts may be billed directly to the insurance company; however, your account is due in full within 60 days regardless of insurance coverage. Finance charges of 1% per month will be assessed thereafter. It should be understood that all services are charged to you, the patient/parent/guardian, who is legally responsible for payment. You, the patient/parent/guardian, agree to pay all collection costs including, but not limited to reasonable attorney fees, late charges, and litigation costs in the event of any breach, including failure to make timely payments.

I have reviewed the above policies; I authorize release of any information relating to my dependents claim or mine. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

X_____ ____/____/____

Signature (patient or parent of minor) Date