

Kathy A Curtis DDS, PLLC
Downtown Dentistry

Office Policy

We are committed to forming a partnership with you to provide excellent dental care. To help achieve this goal, we need your cooperation and understanding, and to inform you of our office policies.

Insurance

The co-payment is due at the time services are rendered for the amount not covered by insurance. If you do have dental insurance, we will gladly send a claim to your insurance company for you. In order to provide this service, we need accurate and complete insurance information from you. Please note that insurance benefits are a contract among you, your employer and your insurance company. Insurance companies are required to respond to a claim within 30 days. If we have not received payment from the insurance company within 75 days, the balance will be transferred to you. Any balance on your account, regardless of insurance, is your responsibility.

_____ Initials

Financial Arrangements / No Insurance

Payment is due at the time services are rendered.

We accept cash, checks, money orders, Visa, MasterCard, Discover and American Express. In order to assist us in containing administrative costs, you may elect to pay the entire cost for your treatment in advance, for which we are happy to reduce the charge to you by 5% if paid by cash, check or money order. Please check with our patient account representative if you would like more information.

_____ Initials

Appointments

Because your dental care is a partnership built on mutual trust, respect and cooperation, it is important to keep your scheduled appointments. If you are unable to keep a scheduled appointment, we ask you to notify us at least 48 hours prior to the appointment time as a courtesy to us and to other patients who may need to be seen.

_____ Initials

We give individualized care to our patients and only schedule one patient at a time. There will be a \$50 charge per half-hour for failed appointments, late notice reschedules or cancellations.

_____ Initials

We are dedicated to helping you achieve excellent dental health. Your participation is vital to success. By working together we should be able to meet this goal. Thank you for your cooperation.

If you have any questions, please do not hesitate to ask. Thank You!

Patient Signature

Printed Name

Date