OFFICE POLICIES

So that you do not incur unexpected and/or unnecessary costs for your dental care, we would like to inform you of our office policies. Many of these policies have been established due to insurance company regulations.

1. *If applicable*, co-payments are due at the time of your visit. We accept cash, checks and credit card payment for your convenience.

2. We participate in many insurance programs, however, it is your responsibility to verify coverage of benefits with your insurance company prior to your visit.

3. We will be happy to process your claim with your insurance company, provided we have accurate and complete information.

4. We will assist you with obtaining any necessary pre-authorization needed to schedule treatment.

5. We will assist you as much as possible in determining the benefit limitations within your dental insurance contract; however, it is your responsibility to determine the limitations of your coverage.

6. You are responsible for any charges incurred as a result of your visit. If your insurance company fails to pay your bill within 90 days, the bill may be transferred to you.

7. If you fail to make prior arrangements with us and your account balance extends beyond 90 days in arrears, your account may be turned over to a collection agency.

8. If you have no insurance, payment is expected at the time of service unless previous financial arrangement has been made with us.

9. There will be a $20.00 fee charged for all checks returned to us due to insufficient funds.

10. Patients under the age of eighteen will not be seen unless accompanied by a parent/guardian, unless we receive a signed authorization from the parent/guardian, which allows the dentist to provide dental treatment.

11. We expect a 24 hour notice prior to the cancellation of an appointment. A $25.00 fee will be charged for any missed appointments. Repeated missed appointments may result in dismissal from the practice.

We make every effort to deliver quality dental care in a caring environment. Dental care insurance is often complex, and we believe a clear understanding of our mutual responsibilities will help us in this effort. Please ask if you have any questions about our office policies. We appreciate your input and will be happy to assist you.

I hereby acknowledge having received a copy of the office polices of
Dr. George V. Picard and Dr. Joel F. Picard.

Signature of Patient/Guardian _____ Date_____