



# CARTER | SLEDGE

Family Dentistry

## APPOINTMENT AND FINANCIAL POLICY

A 24 hour notice is required for all appointment cancellations. I understand that I will be responsible for a \$50.00 charge for all appointments cancelled less than 24 hours. The \$50.00 charge will also apply to any missed appointments in which our office was not notified.

Payment options: Please indicate your method of payment below

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. I authorize the dentist to release any information including diagnosis and the records of treatment rendered to my dependents or me during the period of dental care to third party payer and or health practitioners. I authorize my insurance carrier to pay directly to the dentist. I understand that my insurance may pay less than the actual bill for services and that I will be responsible for payment in full of all remaining balances for services rendered on my behalf and/or that of my dependents regardless of insurance coverage. I further understand that the dental insurance is filed as a courtesy to me. All claims over (30) thirty days that are not paid, will be my responsibility and the balance will be due in full at this time.

I further understand that should I fail to pay my account balance, I will be responsible for all the collection charges incurred, including 40% collection agency fees if placed with a collection agency, plus reasonable attorney fees and court cost if legal action is instituted to enforce collection of any balance owed.

I certify that I have read the above information and fully understand and agree to these terms.

AUTHORIZED SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_