

Capstone Dental Office Policy

Thank you for choosing our practice for your dental care. We look forward to working with you towards achieving your total dental health and beauty goals. Please read our Office Policy and complete our Information and Insurance form prior to seeing the doctor.

BILLING POLICY: If insurance is not being filed, *payment is due at the time of service.* If we are filing insurance, your estimated portion will be collected at the time of service. Payment is accepted in the form of cash, check, debit cards, or credit card (*Visa, MasterCard, Discover, American Express or Care Credit*).

INSURANCE POLICY: Your insurance plan is an agreement between *your insurance company and you.* We file claims to your insurance company as a courtesy to you. The balance on your account is ultimately your responsibility. If your claim is not paid within a reasonable amount of time (determined by the procedure that is performed), the account will be due in full by you. By signing this office policy, you agree to assign directly to Dr. Howard all insurance benefits, if any, otherwise payable to you for services rendered, and authorize the use of your signature on all insurance submissions.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rate.

MISSED APPOINTMENTS: Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointment at *the rate of \$25.00 per 1/2 hour* that was originally scheduled. Please be aware that we have reserved this time for you. If you need to reschedule the appointment, please contact us 48 hours in advance. Please help us serve you better by keeping scheduled appointments.

NOTICE OF PRIVACY PRACTICES: By signing this office policy you also state that you have read the Notice of Privacy Practices located at the front office. You also can obtain a paper copy of this notice upon request.

RELEASE/ACQUISITION OF INFORMATION: I hereby give permission for the office staff of Dr. Steven T. Howard, DDS and associates to contact me at any number or address obtained for the purposes of appointment confirmation, financial or insurance inquiries, or any other purpose deemed necessary. I have also reviewed the Notice of Privacy Practices of Capstone Dental and understand that more information is available upon request. I certify that I have read and understand the above information to the best of my knowledge.

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to the names listed below. If no other individuals are to receive information, please place NONE in the spaces below.

Name	Relationship	Phone Number

Thank you for understanding our Office Policy. Please let us know if you have questions or concerns. Signature below is in agreement that you have read and understand the Office Policy.

Signature of Patient/Parent/Guardian	Relationship	Date