

EXPLANATION OF OFFICE POLICIES

Welcome to our office and thank you for choosing us as your dental care provider. We are committed to providing you with the best in dental care in a friendly atmosphere. Our office policies are:

ASSIGNMENT AND RELEASE

I hereby assign all medical, dental and/or surgical benefits to which I am entitled for the services rendered to Robert S. Wagner, DDS, PC. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not covered by said insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Additionally, I acknowledge that I have read and received a copy of the "Notice of the HIPPA Privacy Practices" with an effective date of April 14, 2003, and I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Name (*Printed*) _____ Signature _____

PAYMENT IS REQUIRED AT TIME OF SERVICE

As a courtesy, we will be happy to aid you in filing your insurance. Remember, however, that your co-payment (the portion that is not covered by your insurance) is due at the time of the visit. Please be aware that your insurance is a contract between you and your insurance company, and we are not a party to that contract. It is your responsibility to make sure that you are covered at the time of service. If for any reason the insurance company does not cover a procedure that was done, **ULTIMATELY IT IS YOUR FULL RESPONSIBILITY TO PAY FOR THE SERVICES.** Parent or guardian is responsible for all the charges for the services rendered to a minor.

In the event that Collection or Attorney services are used to aid in collecting such monies, the patient (parent or guardian of minors) is responsible for any collections, attorney, or court fees billed to Robert S. Wagner, DDS, PC.

Name (*Printed*) _____ Signature _____

APPOINTMENT POLICY

In order to provide our patients with the best care, the majority of the appointment time is the doctor's exclusive time with the patient. As a result, late cancellations and no-shows cause a great deal of inconvenience for our practice and other patients. Should a change be necessary, please at least 24 hours in advance. If not, a broken appointment fee may be charged to your account.

Name (*Printed*) _____ Signature _____