PATIENT RESPONSIBILITIES

First Name

First Name

Last Name

Last Name

Date Of Birth

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. We will take your insurance information and file it on your behalf, however, all charges are your responsibility from the date the services are rendered. Not all services are a covered benefit in all dental contracts. If your insurance distributes payments to you directly, **you are responsible for your entire balance**, due at the time of service. **I understand that it is MY responsibility to determine my eligibility for insurance benefits. 417 Smiles is NOT responsible for determining benefit amounts or eligibility. I understand that I am financially responsible for all charges whether insurance pays or not.** If charges are not paid and no other financial arrangements are made for payment, we may send the account to a collection agency or attorney. I understand that I may be responsible for all costs of collection and reasonable attorney fees.

A monthly administrative charge will be applied to all outstanding accounts 60 days overdue. THERE WILL BE A $25 SERVICE CHARGE FOR ALL RETURNED CHECKS.

We strive to be very considerate of your time, and we ask that you be considerate of ours. Your appointment is time set aside especially for you and we incur costs when appointments are cancelled or rescheduled at the last minute or failed entirely. We ask that 24 hours notice be given if you need to reschedule an appointment so that we might be able to fill your slot.

If, within two (2) years, two (2) appointments are rescheduled without 24 hours notice, we may charge a fee. All failed appointments will be charged a fee. The fee amount will be at our discretion. Additionally, we may require a deposit to hold an appointment time. If the appointment is failed, the deposit may not be refunded. Otherwise, the deposit will be applied to the patient's balance.

At 417 Smiles we adhere to the ADA recommended Standard of Care regarding the frequency of performing dental exams and obtaining dental X-rays. **I understand that my dentist may refuse to perform non-emergency treatment if I refuse necessary diagnostic radiographs and/or examinations beyond the limits of the Standard of Care. If you deny films, insurance may deny your treatment needed and you will be responsible for the account balance if his occurs.**

I hereby assign all dental benefits for services performed at this office to which I am entitled, including private insurance and any other dental or health plans to:

417 Smiles

1824 S. Lone Pine Ave Ste A

Springfield, MO 65804

This assignment will remain in affect until revoked by me in writing. A photocopy is to be considered as valid as any original. I understand that any and all information may be released to secure payment and/or at the request of any other party at my request or authorization.

I have received a copy 417 Smiles Patient Responsibilities.

Sign Here

Submit