TMJ & Sleep Apnea Center **PLATINUM DENTAL, Inc.**
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OFFICE POLICY

We are committed to providing you with the best possible dental care. In order to promote a long-term mutual satisfying relationship we would like to explain our office policy regarding appointment, fees and insurance. Please read the following information.

REGARDING APPOINMENTS:

INT___When you schedule an appointment with us**,** please remember that this time has been reserved for you. When you fail to notify us of your inability to keep your appointment, another patient in need of dentistry is prevented from receiving treatment. A charge of $50 will be made for failed or cancelled hygiene/re-care appointments without **24 hours** notice. A charge of $75 will be made for every half hour of your scheduled appointment time for failed or cancelled restorative (i.e. fillings, crowns, veneers, RCT, and dentures, ect…) appointments without **24 hours** notice.

REGARDING FEES:

Payment for services is due at time services are rendered unless written payment arrangements have been approved.

INT____ For your convenience we accept cash, checks, Visa, MasterCard and Discover.
A $6 sterilization/disposable fee will be collected at each appointment.
A returned check has a $40 fee upon notification to us by the bank, and we require cash or credit card as alternative payments.
Duplication of X- rays has a $35 fee, due prior to duplication process.
Unpaid balances over 30 days will be assessed monthly interests at the rate of 5% per month.
Unpaid balances over 90 days are subject to collection. If it becomes necessary to institute collection proceedings, I agree to pay any and all cost related to the collection action but not limited to, 30% collection agency fee, court costs and attorney fee.

We will gladly discuss your proposed treatment and answer any questions relating to your account. We will not perform any procedure without you knowing the estimated cost of the treatment upfront.

INT____ REGARDING INSURANCE:
As a courtesy to you, we can file your insurance claim on your behalf. A $7 insurance processing fee will be collected for each claim.

As far as your insurance is concerned, please realize the following points:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. We do not render our services on the basis that insurance companies will accept or pay all our fees. Each fee is individual for the patient.

We must emphasize that as dental care providers, our relationship is with YOU, not your insurance company. If your insurance company fails to pay the portion they have estimated to pay, you are ultimately responsible for the balance due. ALL charges are your responsibility from the date services are rendered. In order to process your claim, we must have complete insurance information. If questions or concerns arise, we encourage you to contact us promptly for assistance in the management of your account. We are here to help you.

By signing your name below, you have read and understood our Office Policy.

_____ _____
Signature (Patient/Responsible Party) **Date**

_____
Patient Name (Print)