CAMBRIDGESIDE DENTAL ASSOCIATES

FINANCIAL POLICIES FORM

Thank you for choosing our Practice! In an effort to better serve you, we would like to take the time to explain the billing process at our office.

Payment is expected the day services are rendered. For patients with dental insurance, if you provide the office with your dental insurance information, we will contact your insurance company and verify your benefits. We will do our very best to answer any questions you may have about your insurance coverage but always suggest that you contact them directly whenever possible.

As a courtesy to you, we will gladly submit the insurance claim to your insurance company on the day of service. We will collect the estimated copayment and deductible at each visit. We make every effort to determine your insurance benefits when you receive treatment but consider your copayment an **estimate** until we receive payment from your insurance company. Please remember that any information we provide relative to your insurance coverage is our best **estimate** and not a guarantee of the payment that will be received.

In order to provide quality dental care in a timely manner, we have a cancellation and no-show policy. The policy enables us to better utilize available appointments for our patients in need of dental care

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to keep your appointment. This time will be given to someone who is in urgent need of treatment. We ask that you notify us 48 business hours in advance, in order to cancel or reschedule any appointments.

NO SHOW POLICY

A "no show" is an appointment that was not cancelled in advance (48 business hours). No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will be charged $50.00 if scheduled with a hygienist, or $100.00 if scheduled with the dentist.

LATE ARRIVALS

If you are running late for your appointment, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

I have read and understand the appointment policies at Cambridgeside Dental Associates. I have also read and understand the billing procedures at Cambridgeside Dental Associates. I agree to be responsible for full payment of all charges for dental services performed on me. If for any reason the insurance does not pay its estimated portion, I agree that I will be responsible for the account balance. In the event that my account is placed with third party collection agency or attorney, I will be assessed any fees relating to this action.

Print Name: ___________________________________

Signature: _____________________________________

Date: ____