OFFICE POLICY

OUR MISSION STATEMENT: To provide excellence in dentistry

To ensure that superior continuing dental care is the top priority in all future contact between you and our staff, our office would like to make you aware of our policies pertaining to payment of account and cancelled or missed appointments.

For Patients With Insurance Coverage:

We are able to accept direct payment from your insurance plan, however, please be informed that YOU are responsible for all balances NOT covered by your insurance plan.

If you are uncertain about your insurance plan coverage for specific treatment, we can submit a pre-determination of benefits form to your insurance company in advance to determine what amount you are responsible to pay. You are under no obligation to continue with any such treatment and we will be available to discuss alternative treatments.

For Patients With No Insurance Coverage:

According to our standard policy, full payment is due at the time service is rendered. Payment may be made using Cash, Debit, Visa or Mastercard. Under special circumstances, alternative payment arrangements may be made in advance. We reserve the right to levy a financing charge of 2% monthly on any balance owing 30 days from the date of treatment. As well, NSF cheques will be subject to a $15.00 additional charge to cover administrative and bank fees.

Cancellation Notice:

We request 48 hours notice in the event that an appointment must be cancelled. Short notice cancellations and missed appointments are subject to a $50.00 charge.

PRIVACY INFORMATION

I understand that any personal information collected during my visit(s) to this office will be used only for providing appropriate health/dental care and accounting purposes. This may include consultation with my family doctor/dentist and any other health care provider as may be necessary. This may also include contacting and sharing billing information with my insurance company as it relates to my financial account with this office. I understand that the health care provider reserves the right to determine which cases fall outside of his/her scope of practice, on which event the appropriate referral will be recommended. I authorize release, to my dental plan benefit administrator and Canadian Dental Association, of information contained in claims/predeterminations submitted electronically. I hereby assign my benefits. If needed, payable from claims submitted electronically, to Northlake Dentistry, and authorize payment directly to Northlake Dentistry.

I hereby acknowledge that I understand and agree to the office policy and privacy information disclosure.

Print Name ________________________________ **Date** ________________________________

Signature __________________________________

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