



Garret Family Dental Care
15009 West Bell Road, Suite 175
Surprise, Arizona 85374-3213
Phone 623.476.8100
Fax 623.792.5311
garrettdental@gmail.com

OFFICE POLICIES

Please take the time to review the following policies and procedures that we have set in place to better serve you. We look forward to establishing a long and wonderful relationship.

PAYMENT

Payment is required, in full, at each visit. This may include a deductible, co-payment, and/or insurance percentage. If you are waiting for coverage to become effective, or have no insurance, payment will be expected at the time of the visit. For your convenience, we accept cash, checks, Visa, Master Card, American Express, Discover, & Care Credit.

There is a \$25.00 charge for all returned checks. Each time the check is run through, at the bank, there is an additional \$25.00 charge, until funds are available for payment. NSF checks must be redeemed with certified funds. The following certified funds are accepted: Cashier's check, money order, certified check, or cash.

BILLING & INSURANCE

The Office Manager handles all claims and billing questions. You can reach her by calling (623) 476-8100. You will then be put through to her voice mail. Please leave a detailed message and she will return your call in the order received. Calls will be returned anytime within 7 business days, depending upon the nature of the call and the research needed.

Due to all various insurance plans, now in effect in the market place, it has become a very complicated process to become familiar with each plan. Therefore, we are requiring your cooperation so that we may better help you, thus, giving you the proper dental care that you deserve. This can then be accomplished, without spending an exorbitant amount of time, obtaining benefit information, from your insurance company. Please be aware that we do not bill procedures to medical insurance.

IT IS YOUR RESPONSIBILITY TO KNOW ALL OF THE INFORMATION REQUIRED BY YOUR INSURANCE PLAN. THIS WILL AVOID ANY CONFUSION, DELAY IN TREATMENT, OR NON-PAYMENT OF SERVICES.

Please be aware that an authorization from your insurance company, for treatment, is **NOT** a guarantee of payment. **Any dental claims not paid within 90 days, becomes the responsibility of the patient. The remaining balance on the account is due immediately.**

Any accounts with outstanding balances, greater than 90-days, from the date of service, will be turned over to a collection agency. You will be held responsible for any attorney and/or court fees, not to exceed 50% of the balance. In the event that this indebtedness is referred to a collection agency for collections, you expressly agree to pay, to the collection agency, 25% of the principle amount assigned to the collection agency as a reasonable collection fee. I understand that 25% of the principal amount assigned may be more or less than the actual costs. We also reserve the right to charge a monthly late fee not to exceed 10% per annum. We realize at times that there may be a financial hardship. Please communicate this with our office and they will assist you.

RECORDS & X-RAYS

In the event of having records transferred to Garrett Family Dental Care, **please be aware that we only accept digital x-rays and they must be e-mailed to us.** This is due to lack of quality in duplicated x-rays and the necessity of x-rays, on file, for insurance purposes.

There is a "DUPLICATION FEE" of \$25.00, for each individual patient, when requesting that your x-rays (taken at our office) be emailed to another dentist or printed. Please note we require 24 hour notice for all x-ray and record requests.

X

Signature of Patient or Responsible Party

Date





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SCHEDULING

We require that you notify the scheduler when you make your appointment, of any of the following; change of insurance, address, telephone number, and emergency contact. By doing so, this will eliminate unnecessary delays in your care.

We give reminder calls as a courtesy to our patients. Once in awhile certain circumstances prevent us from being able to give a reminder call. It is the patient's responsibility to keep track of their own appointments. We recommend that you do not depend on a call from our office as a reminder. **We require that patients call to confirm their own appointments. If an appointment is not confirmed, it may be cancelled without notice to the patient.** It is then the patient's responsibility to re-schedule the missed appointment.

Please be aware that failure to call and cancel your appointment may hinder another patient's ability to be seen by the doctor. **Therefore, we request a call 24 hours prior to the patient's scheduled appointment. Otherwise you may be subject to a "MISSED APPT/24HR NOTICE" fee of \$40.00.** Repeated missed, canceled, or re-scheduled appointments, without 24 hour notice, may be subject to the patient's discharge from the practice.

If you are unable to arrive for your appointment on time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be re-scheduled or worked in behind the existing scheduled appointments.

ACKNOWLEDGEMENT AND AGREEMENT

BY SIGNING BELOW, I AM STATING THAT I HAVE RECEIVED AND READ THE FOREGOING OFFICE POLICIES. IN ADDITION, I AM STATING THAT I AND MY DEPENDENT(S), ON FILE WITH GARRETT FAMILY DENTAL CARE, AGREE AND WILL ABIDE BY THE TERMS OF THESE POLICIES. THESE OFFICE POLICIES ARE SUBJECT TO CHANGE WITHOUT NOTICE. YOU MAY REQUEST AN UPDATED COPY AT ANY TIME.

X

 Signature of Patient or Responsible Party

 Date

 Print name of Patient or Responsible Party

 Relationship to Patient

