Tri-Cities Center for
Cosmetic Dentistry
KATHY S. SANDERS, DMD, FAACD

***Welcome!*** We are pleased you have chosen us for your dental needs! While you are in our care, it is our desire to provide for your dental health as thoroughly and accurately as possible. To ensure a successful relationship, we believe it is important for you to understand the following guidelines and policies of our dental practice. ***Please read each item carefully and initial at the conclusion of each section to signify your understanding. Your signature will be required at the conclusion of the document***. If you have any questions, please talk with one of our team members.

## Appointment Commitment Agreement

We take pride in our work and strive to stay on schedule for the convenience of our patients. Unfortunately, we do occasionally get behind schedule due to procedures, which are more complex than anticipated, emergencies, etc. For this occasional inconvenience, we apologize.

Appointment commitments are taken very seriously at this office. Appointments are arranged at a time when you, our valued patient, have agreed to be available and we feel that we will have sufficient time to provide high-quality service. We reserve time, personnel and equipment for your specific needs and it is very important that you arrive at or before the agreed upon time.

In the event you must reschedule, we need as much advance notice as possible. Missed appointment commitments are noted in our permanent records.

**PLEASE NOTE:**

- Patients who are late and/or miss more than two consecutive appointments without giving a minimum of 48 hours notice will incur a missed appointment fee of $100 and/or will be released from our care.
- Patients scheduled for appointments of 3 hours duration or longer must provide a minimum of 7 days notice before rescheduling or canceling the appointment. Otherwise a $500 broken appointment fee will be assessed and/or will be released from our care.

We commit to doing everything within our ability to serve you at the appointed time. We ask that you likewise commit to keeping your appointment with us.

__________ **(Please initial)**

## Financial policies & Dental Insurance

- **First Appointment:** It is our request that the complete amount of your "initial" visit be paid by you the day of your exam. We will file the claim for reimbursement directly to you.

- **Future Visits:** If there is any complexity to your dental needs, we will provide a treatment plan for your approval. This will enable you to plan for your dental care and financial obligations. While working through a treatment plan, procedures are to be paid in full no later than one week in advance of treatment. Any insurance reimbursement will be sent directly to you from your insurance provider. If funds are mistakenly sent to our office, a reimbursement check will be forwarded to you.

**THIS DOCUMENT IS CONTINUED ON THE OTHER SIDE.**

- **Maintenance Visits:** Hygiene and small treatment procedures needed to maintain your dental health over the years would be filed with your primary dental insurance. If you have any secondary insurance, you will need to file with them directly. Your co-pay will be due the day of treatment. We expect final payment once the amount of insurance reimbursement is received. Any balance on your account after insurance payment or denial is the responsibility of the patient.

__________ **(Please initial)**

## Photography Release

Often times, your dental treatment may include digital photography as a part of your dental records. These items may be used by the Tri-Cities Center for Cosmetic Dentistry in relation to dental education, presentations, training or any future use.

______________ **(Please initial**)

## I understand …

Please print your name and sign below to signify that you have read, understand and initialed the appropriate sections of this document regarding your dental care within our office. Your signature signifies that you are aware of our office policies/procedures and that you are in agreement.

________________________________

Patient Name (Please print)

________________________________ __________ ________________________________

Patient Signature Date New Patient Coordinator/Front Office Coordinator