MEADOWS
DENTAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

Thank you for choosing Meadows Dental Group for your dental care needs. The following information will explain our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible. Financial arrangements must be made prior to treatment.

- Payment is due in full at the time of service for patients without dental insurance. Patients with insurance coverage are responsible for any deductibles and estimated co-payments at the time of service.
- Third party financing is available for patients requiring extensive treatment ($300 or more with approved credit). See our Treatment Coordinator for more details on the Care Credit program.
- In the event you would like to pay up front at the time of service in cash/guaranteed funds, we would not process a credit inquiry. However, when we bill insurance and accept assignment of future insurance and patient payments, we do reserve the right to run a brief credit inquiry in order to establish a history with the patient.
- **A 24 hour notice is required to reschedule/cancel an appointment or a $75.00 fee will be applied.**

A word about Dental Insurance-
As a service to our patients we will bill your insurance company. However, your insurance policy is a contract between you and your insurance company. You are responsible for any fees insurance does not pay. The remaining balance is the responsibility of the patient. Please refer to your employee manual for specific coverage explanations. **If your insurance has not paid within 60 days we ask you to clear the balance within 15 days.**

If you have any questions regarding treatment, fees or services, please feel free to discuss them with us at any time. Provisions and policies contained in this agreement may change without prior written notice.

I understand and agree to abide by this Financial Policy.

_____ _____

Signature of patient/responsible party Date