

LEGACY RANCH DENTAL
FINANCIAL and CANCELLATION POLICY

Financial Policy:

We require payment in full for services rendered at the time of visit if you do not hold dental insurance that is a PPO or higher. We accept Cash, Visa, Discover, American Express, Master Card, and CareCredit.

As a courtesy, we will file all primary insurance for you as long as it is a PPO dental plan. We do not file secondary insurance and do not accept discount plans or HMO dental plans. **It is YOUR RESPONSIBILITY to present our office with your most current insurance card and information.** Failure to do so may cause you to be responsible for the entire account balance.

Payment of services, applicable deductibles and co-payments are due at time of your visit. We will **ESTIMATE** the portion to be covered by your insurance and your financial obligation for each dental procedure. This is **ONLY** an **ESTIMATE** until the claim is paid by your insurance. You are responsible for all amounts not covered by your insurance company. If you have questions regarding your insurance benefits you will need to contact your insurance carrier directly. (refer to the back of your card.) We will inform you of any outstanding balances after we receive payment from your insurance with a statement and our office does expect payment within 30 days or we reserve the right to ask an outside collection agency to collect these fees that are your responsibility.

Cancellation Policy:

All responsible parties and family members involved will be asked to notify our office of any appointment cancellations or rescheduled appointments at least **24 hours** in advance by calling our office directly and speaking with an office staff member. **NO voice mails or emails** will be considered as notice. We reserve the right to charge you (not your insurance company) for a missed or rescheduled appointment. There is a **\$35 service fee** for all failed or cancelled appointments without a **24 hours notice**. If for any reason there are 2 failed or canceled appointments without notice, **ALL** patients will be asked to find another provider. The purpose for this charge is that the appointment time scheduled with the dentist or hygienist was reserved for you. Out of consideration for another patient who may have needed that time, and in respect for the dentist who designated the time for you, this charge may be imposed.

Thank you for respecting our Financial and Cancellation Policy.

I have read, understand, and agree to the above Financial and Cancellation Policy.

Patient or Responsible Party

Date

Printed Name

Witness