Carlton Dental

OFFICE POLICIES AND DISCLOSURES REQUIRED BY FAIR CREDIT BILLING ACT

OFFICE HOURS:
Office hours are available by appointment. Presently our office is open **Monday** 9:00am to 6:00pm, **Tuesday** 9:00am to 6:00pm, **Wednesday** 9:00am to 6:00pm, **Thursday**, 9:00am to 6:00pm. These times are subject to change without notice. After hour appointments may be subject to an additional fee.

CANCELATION:
When we reserve an appointment for you, it is not possible to schedule other patients or procedures at the same time. If you cannot keep your appointment time that was reserved for you, our team will be idle. Thus affecting the cost of dental care. Consequently, **YOU SHOULD TRY TO CANCEL YOUR APPOINTMENT WITH A MINIMUM OF 24-HOURS OR A FEE MUST BE CHARGED TO COVER THIS TIME. THIS CHARGE IS DUE AND PAYABLE BY YOU.** Your insurance company will not be billed for this charge. Our office may wave this fee in the event of certain circumstances.

STATEMENTS:
We will furnish you a monthly statement of your account, showing the amounts billed and credited to you, by us for the month, with a breakdown of the length of time you have had an outstanding balance on your account. After your insurance has paid the agreed contracted percentage of treatment, procedures, you are responsible for and will be billed for the balance.

FEES AND FINANCIAL POLICIES:
WE WILL NOT FINANCE IN OFFICE ACCOUNTS OVER $500.00.
Payment of fees is **YOUR** direct responsibility. We encourage payment at the time of service. All charges are due and payable within **30** days after billing, unless you have talked to our office manager to arrange a payment plan. In the event any balance is not pain within **60** days, the undersigned jointly and severally agreed to pay all attorney's fees, court costs, up to 50% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay **INTEREST** at the rate of **1.5% per month on the unpaid balance** (18% per year). the amount on which the periodic rate is applied shall be the outstanding balance 30 days or more old as the date of each monthly statement, after deducting all current payments shown on each statement. All payments shall be applied to the oldest charge first.

INSURANCE INFORMATION:
Our office will bill your insurance company for you as a service to you. We will assist you in any way that we can to complete the insurance forms for prompt reimbursement. However, our office cannot accept the responsibility of collecting your dental insurance claims or negotiating a settlement on an account within the limits of our credit policy. We expect regular co-insurance payments even though you have an insurance claim pending. **REMEMBER: Your** dental insurance is a contract between **you** and **your** dental insurance company. If we are not currently listed as a provider with your dental insurance company, the payment for service is your responsibility. It is also **YOUR RESPONSIBILITY TO DETERMINE IF DR. CARLTON IS CURRENTLY A PROVIDER ON YOUR INDIVIDUAL INSUANCE PLAN. YOU ARE RESPONSIBLE FOR ALL CHARGES YOU INCUR REGARDLESS OF INSURANCE COVERAGE.** I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

AUTHORIZATION AND ACKNOWLEDGEMENT:
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I furthermore acknowledge receipt of a copy of this disclosure and the information regarding billing errors and inquiries prior to extension of credit. A photographic copy of this authorization shall be as valid as the original. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. Please sign and date this form after reading it, saying that you understand all of the above information.

SIGNATURE:____ **DATE:**_______________________