DENTISTRY AT Springhurst
JILL M. LUCKETT, DMD

Patient Agreement

As your dental care provider, we are committed to providing you with the best possible dental care. In order to achieve this goal, we need your assistance, and your understanding, of our payment policy.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED – We accept cash, personal checks, Mastercard, Visa, American Express, Discover, and financing such as CareCredit.

RETURNED CHECK FEE – Returned checks are subject to a service charge of $25 that is charged to us by our bank. You will also lose the privilege of using personal checks in our office.

By signing, I acknowledge that I have read and understand the above Patient Agreement.

Insurance Agreement

We are committed to providing you with the most comprehensive dental care using high quality materials and the most advanced technology available. We will always recommend treatment based upon your dental needs, not based upon insurance coverage, which can be inadequate with some plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment.

As a courtesy, we will attempt to verify your insurance benefits and eligibility, and we will file claims on your behalf. However, your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract; we are only obligated to honor the allowed fees.

Please initial all areas below to indicate your understanding.

_____ 1. I understand payment is due at the time of service for me, or any party for whom I am financially responsible.

_____ 2. I understand that it is ultimately my responsibility to understand which treatments or procedures are payable by my insurance. This includes any applicable exclusions, deductibles, maximums, and waiting periods.

_____ 3. I understand that insurance claims will only be filed if I provide the social security number or alternate insurance membership ID, as well as the correct name of the insurance company and subscriber's employer. I also understand I am responsible to notify the office of any changes to my insurance company.

_____ 4. I understand that the estimated patient balance or co-pay on the date of service may differ from the insurance company's final payment. I understand I will be responsible for any amounts not paid by my insurance company.

_____ 5. I understand that if I discontinue treatment of a requested procedure, I remain responsible for paying all related lab costs and services incurred before treatment was discontinued.

No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand and limited availability of appointments, we have instituted a **$25 No-Show Fee per Hour**. You must give a 24-hour advance notice to cancel or reschedule any appointments. Failure to do so will result in a $25 fee charged to your account for every hour that was reserved for you.

By signing, I acknowledge that I have read and understand the No-Show Policy.

Records Release

As a patient, I understand that at times it is necessary for Dentistry at Springhurst to release my dental records and x-rays to insurance companies, other medical professionals, and/or dental specialists (ie: oral surgeons, etc.)

By signing, I give permission to Dentistry at Springhurst to release any dental records if necessary.

_____ _____

Patient/Legal Guardian Signature Date

_____

Patient's Printed Name