Acknowledgment of patient responsibility

1. Dentistry Bliss is proud to offer expert assistance in maximizing your insurance benefits and filing your claims. We work with many insurance companies and will verify your insurance plan with our selected list of quality dental insurance programs. Our insurance department will provide as much information of your policy as possible. However, payment for services is always the responsibility of the policy holder. Please keep in mind; you are responsible for any less fees or amounts not covered under your policy. Any co-pays due will be collected prior to appointment.

2. I agree to pay any portion of the fees not covered by my insurance company for **ANY** reason. **I understand that any prior balance or co-pays due will be collected prior to services being rendered. We accept cash, check, and credit cards. (There is a $30.00 additional charge for returned checks.)**

3. I understand that Dentistry Bliss can only **ESTIMATE** the approximate percentage or amount that my insurance company will pay. I understand that my balance remaining on my account after 30 days due to nonpayment based on the quality of care for patients, not the standard set by any insurance company. **I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due to payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 _% finance charge (18% APR) may be added to my account. In addition to any collection charges.**

4. **I understand that is my responsibility to know the paying guideline in reference to cleanings, fluorides and exams for my family members and myself.** I understand that Dentistry Bliss will recommend treatment based on the quality of care for patients, not the standard set by any insurance company.

5. Fees quoted are in effect for **90 days** and are subject if the treatment does not being within 90 days.

6. I understand that if treatment is started and not completed and Dentistry Bliss incurs lab fees, the office has the right adjust the balance on my account and charge for temporary services (including doctor time and lab fees.) I understand that if I do not complete treatment as recommended the previous adjustments will apply. Any monies rendered will be retained to cover these fees.

7. I understand that Dentistry Bliss will keep and apply any monies I have paid towards the treatment started. Treatment not completed within 90 days of the start date (unless otherwise specified) will be considered incomplete treatment and the previous mention adjustments will apply. Treatment resumed at a later date will be charged a fee at my scheduled appointment or when billed by Dentistry Bliss.

8. **I understand that Dentistry Bliss has a 24-hour cancellation policy and will charge an appropriate fee for appointments that are cancelled with less than 24 hours.**

Cancellation of appointments with **less than 24 hours** notice or arriving **more than 15 minutes** late constitutes a missed appointment. **Missed appointments are subject to a $50.00 fee.** I understand that I will be responsible to pay these fees at my next scheduled appointment or when billed by Dentistry Bliss.

9. I understand that Dentistry Bliss will be happy to duplicate and make available to me at my request any x-rays that have taken for the purpose of diagnosis. **I acknowledge that Dentistry Bliss will need a minimum of 48 hours notice for any duplicate request.** I understand that Dentistry Bliss will keep the original x-rays on file and I will receive a duplicate or copy of the x-rays. **I agree to pay the minimum duplication fee of $20.00 for these x-rays and sign a record release form as required by law.**

Signed_____