Millard Roth, DDS

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OFFICE POLICY

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.

METHOD OF PAYMENT

1. Cash , Check or Credit Card (MasterCard, Visa, Amex and Discover)
2. Dental Insurance (described below)
3. Care Credit (Application available upon request)
4. Online payments are accepted at www.patientconnect365.com

DENTAL INSURANCE

1. We are pleased you have dental insurance and our office will assist you in obtaining the maximum benefits specified within your insurance contract. However, your insurance contract is between you, your employer and insurance company. If you like help interpreting your benefits you can provide us with a copy of your booklet of coverage. We can provide a generalized breakdown of your benefits provided by your insurance company.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization form. We ask that your estimated copayment and deductible be paid at the time of service.
3. Not all services are a covered benefit in all contracts. It is your responsibility to read the fine print of your insurance contract as they all vary from person to person, insurance to insurance company as well as employer to employer. Some insurance companies arbitrarily select certain services they will cover and will not.

RELATED INFORMATION

1. Returned checks and balances older than 30 days are subject to billing charges.
2. In the event your account is not paid and we have to refer to collections, you will be responsible for all fees incurred in attempts to collect the debt (i.e., attorney fees, court costs, and any collections fees).
3. **Your appointment has been reserved exclusively for you. Any changes in your appointment affect your visit as well as other patient's appointments and wait times. <u>There is a 48 hour notification requirement to cancel appointments.</u> $50 per hour of time reserved will be charged for missed or canceled appointments without a 48 notification.**
4. Note: All payments are due at the time of services are rendered unless other arrangements have been made.

I have read and understand the above information. I understand I am financially responsible for all services that are rendered under the care of Dr. Millard Roth and Associates.

Name (please Print) _____ Date _____

Signature (Patient or Patient/Guardian of minor) _____