FOY DENTAL CARE
OFFICE POLICY

Welcome to our practice! We are dedicated to performing high quality dental care using the latest dental technology advancements in a caring and friendly environment; providing our patients with a uniquely positive dental experience . We thank you for choosing to be a part of our dental practice and welcome your referral of family and friends.

APPOINTMENTS

*Once an appointment is made, please remember that this is time reserved specifically for you.
*****If you must change your appointment time, Foy Dental Care requires a 48 hour (at least 2 business days) notice on any cancellation or re-scheduled appointment.(Legitimate emergencies are exceptions)
*****We reserve the right to assess a fee for time reserved for an appointment in which two-business day's notice is not provided to our office. This fee can range from a minimum of **$25.00 to a maximum of $250.00 per half hour,** for routine preventive and restorative procedures. **For longer more complex restorative and cosmetic procedures, the fee will be determined on a case by case basis.**
*****Cancellation or appointment changes must be handled by a staff member and not via our voicemail system or email.

Patient:_____ Staff:_____

PAYMENT AGREEMENT

*For and in consideration of the provisions of services, I accept the fee charges as lawful debt and promise to pay said fee in full for all charges.
*We accept cash,personal check, MasterCard, Visa, American Express or Discover card. We do not accept post dated checks.
*Extended payment plans and interest free financing plans are available through **Care Credit**.
***** Foy Dental Care will make every effort to minimize bookkeeping errors. **Should an error result in a debt owed to us, we will provide a correct statement and allow an additional 10 days for payment to be rendered in full. Should an error result in a credit, you may leave the credit on your account or request a refund. We will process refund requests within 10 business days.**
*In the event payment is not received by the agreed upon dates, I understand that my account may be subject to **1.5% finance charge per month 18% finance charge per year and that I may also be responsible for a $25 monthly rebilling fee.**

COLLECTIONS:

*Foy Dental Care reserves the right to assess a service charge of $36.00 for all returned checks (or maximum allowed by law)
*Foy Dental Care also reserves the right to forward any and all accounts over 90 days past due to an outside collections agency.
*I the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all necessary **collection agency fees (33.33%)**, attorney fee and or court cost, if such be necessary. I waive now and forever my right of exemption under laws of the constitution of the state of Alabama and any other state.
*I authorize Foy Dental Care to contact me at any numbers including my cell phone for the purpose of treatment,insurance, or payment for services rendered
*I waive all rights of exemption under the constitution and laws of the State of Alabama.
*I further authorize Foy Dental Care to receive and exchange credit information.
*I here by authorize release of medical information for all insurance claims and payment of my group insurance benefits, otherwise payable to me, to the dentist.
*I further agree to accept and adhere to the above office policy of Foy Dental Care.

Patient/Guardian:_____ Date:_____ Staf:_____

For Patients With
Dental Insurance

*****If you have dental insurance coverage, Foy Dental Care will file your dental claims as courtesy to you.

*****Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party and the Patient/Responsible Party is personally responsible for payment of all fees.

***WE DO NOT** render our service on the basis that insurance companies will pay any or all of our fees.

*****All patient co-payments and deductibles, as required by your specific insurance coverage, are due and payable at the time of EACH VISIT.

*****You are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeat filling of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to re-filling fee of **$20.00 per claim.**

*****If payment of your claim has not been received **for any reason** within **45 days from the date of servic**e, you, the patient/responsible party, will be responsible for any unpaid balance.

*****If your insurance company pays less than the estimated benefit, you will be responsible for any unpaid balance.

*****If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. At such a time that we determine that payment was not in error, you may either leave the credit on your account to be applied to charges for the future care, or you may request a refund. Foy Dental Care will make every effort to process refund requests within 10 business days from the date request is received.

Patient, Parent or guardian Signature: **Date:**

_____ _____

Staff:

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