Office Policy

We are pleased to welcome you to our practice. Our desire is to provide you and your child(ren) with the highest quality of service and dental care in a caring and enjoyable atmosphere. To be fair to all, we ask that you read and remember the following policies:

1. Always bring the patient's proof of insurance.
2. Let us know if there are any changes of address, phone numbers, etc.
3. **Please be on time** for your appointment. We have reserved a particular time for you, and we want to stay on schedule. If you are late, your appointment may be rescheduled.
4. **If you cannot make your scheduled appointment and do not call 24 hours in advance to reschedule or cancel your appointment:**
    - Your appointment will be considered as a **"No Show."**
    - We understand that unexpected events arise and we try to work with our families as best we can.
    - **2 No Shows/Broken Appointments** and the family will be dismissed from the practice.
    - In the event that you are dismissed from the practice, we will **only provide emergency dental care** for 30 days. After the 30 day period ends, we will no longer see your child in our office.
5. If you do not have insurance, payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover, and Care Credit.
6. For new patient and emergency visits, we require payment in full at the time of the appointment.
7. All restorative visits, patients must pre-pay in order to schedule that visit. If nitrous is needed, you must pay an additional **$76** for this procedure as insurance companies do not pay for this. If you do not show up for a restorative visit, your account will be charged **$100.00**.
8. There will be a **$35** service charge for all returned checks.
9. Any balance on the account after insurance has paid, payment is due in full when statement of account is received.
10. There may be times that Dr.Vickers is out of the office; however patients may still be seen by our hygienists under the ADA supervisory law. You will be made aware in advance if this situation should occur.
11. Please note that your information will and can be shared through email and electronic files to insurances and other healthcare providers.

AUTHORIZATION

I have read and accept the above office policy, understand it and agree to the terms set forth regarding payments.

Signature:_____ **Date:** _____