FOREST CREEK
FAMILY DENTAL, P.A.

Teri B. Gaddy, DDS

OFFICE POLICIES AND PROCEDURES

Welcome to Dr. Gaddy's office. We would like to take this opportunity to personally thank you for choosing our office to treat your dental needs. Below is a list of our office policies. Please take a moment to review and do not hesitate to ask any questions.

Appointments: Your scheduled appointment time has been reserved specifically for you. We request that you call to cancel your appointment within 24 hours. After missing your second appointment without notifying us 24 hours in advance, you will be charged $50.00. As a courtesy to the doctor and to other patients, we require that you be on time for your appointment. If you are more than 15 minutes late for your scheduled appointment, your appointment may be rescheduled.

Insurance: Your insurance coverage is a contract between you and your insurance company. We are NOT an in-network provider. As a courtesy, we will be glad to file your primary insurance claim for you to help you maximize your benefits. We can only estimate your coverage in good faith and cannot guarantee coverage. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. By signing below you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance company.

Payments: Your estimated portion of payment is due at time of services. Our office has several financial options from which to choose:

-Cash
-Personal checks
-Major credit cards (Visa, Mastercard, Discover, American Express)

In some cases, it may be possible to pay for the treatment with 50% due on the day of treatment and balance due in a subsequent payment.

For patients who wish to pay for treatment over an extended period of time, we offer a payment plan that is administered by an independent company. The Treatment Coordinator can provide you with all the details.

Monthly Statements: You will receive a statement only if you have an outstanding balance on your account. We request that if you receive a statement you make payment within 30 days of receipt.

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Signature of patient/guardian **Date**

I hereby acknowledge that I have been given the opportunity to review a copy of the HIPPA Privacy

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Signature of patient/guardian **Date**

Revised 1-2014