

OFFICE POLICIES

Broken/Cancelled Appointments: In the event you need to cancel an appointment, we request notice at least 24 hours in advance of the appointment. As a courtesy, our office may contact you via email or phone to remind you of the appointment(s). While certain emergencies and other issues may be taken into consideration, Dr. Jaconetti reserves the right to apply a fee of \$25.00 per half-hour of the scheduled for failure to provide adequate notice.

Guarantee of Payment/Assignment of Insurance Benefits: Unless otherwise stated, I understand that fees are due for any services rendered on the date of service to me to be made directly to this office for benefits otherwise payable to me. These payments shall not exceed the regular charges for this period of treatment. I also understand that I am responsible to pay any charges not covered through my insurance benefits, including but not limited to non-covered services, applicable deductible and/or co-insurances as defined by my policy(ies) or, any fees for services in the event that I do not have insurance coverage.

Required Payments: Payments and any co-payments required by an insurance company must be paid at the time of service.

Past Due Balances & Collection Services: Dr. Jaconetti makes an effort to provide all patients with education and information regarding proposed and completed treatment as well as the costs associated, in order for each patient to make an informed decision regarding treatment. Dr. Jaconetti also participates in lending programs to extend interest-free credit to qualified applicants for certain procedures. However in the event that I do not pay outstanding balance(s), I understand that an 18% annual interest rate will be applied to any past due balances. I also understand that my past due balance be referred to an attorney or a collection agency, I will be financially responsible for any additional costs incurred such as attorney fees collection agency fees, court costs, etc.

In the event this account goes unpaid and Dr. Jaconetti is forced to use an outside collection agency and/or an attorney, it is understood and agreed that all collection/attorney's fees will be added to the principal balance. In the event Dr. Jaconetti is forced to file suit to collect the unpaid balance, it is understood and agreed that I will be liable for all court costs and attorney fees, whether judgement has been entered or not.

Completion of Treatment: In the event that I elect to receive treatments such as crowns, dentures, root canals, bridges, implants and other treatment that requires me to return for future visits to finalize, I understand that I am responsible to return to the office to complete treatment. These types of treatments typically require Dr. Jaconetti to incur lab, equipment and labor costs upfront. In the event that I do not return to complete the treatment, I understand that I am still responsible to pay the full cost of the treatment.

Patient Dismissal: Our practice takes pride in our dentistry and in the relationships with our patients who believe in quality care. Cooperation is a key element to successful treatment, Dr. Jaconetti reserves the right to dismiss patients in the interest of customer service and quality care for all patients Dr. Jaconetti will be happy to transfer patient records to another provider at the request and approval for any patients who are dismissed.

I agree to abide by the policies listed. I understand that if I have any questions about these policies, I may request assistance and further explanation at any time from a Dr. Jaconetti staff member.

PATIENT/RESPONSIBLE PARTY NAME

DATE

PATIENT/RESPONSIBLE SIGNATURE

STAFF WITNESS

DATE

Last updated: January 5, 2018