CANCELLATION POLICY

- We require 24 hours advance notice for canceling or rescheduling an appointment; otherwise a $25 fee will be assessed to your account.

PAYMENT INFORMATION

- We will discuss financial options with you before rendering treatment and by signing the Financial Responsibility Agreement you are agreeing to all of the terms contained in this Consent for Services.
- Treatment estimate does not include any type of general dentistry, oral surgery, or periodontal treatment that may be needed prior to or during your orthodontic treatment.
- Treatment plan may be subject to change after review of orthodontic records.
- If you decline treatment after records have been taken, the patient/ guardian are responsible for a fee of $350.00.
- Any account balance not paid within 90 days will be subject to collection activity.
- I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the account.
- There is a $35.00 service charge on all returned checks.

INSURANCE

- Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, whatever the reason.
- On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.
- Your insurance policy is a contract between your employer and your employer's insurance company, we are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
- We generally will accept assignment of benefits (payment) from your insurance company but we reserve the right to refuse assignment on certain plans. In that case, full payment is due by you at the time of service and your insurance company will reimburse you directly.
- In the event that you wish to have us invoice your insurance company directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Legacy Orthodontics.