

Dear New Patient:

Welcome to Associated Dental Group of Weymouth. This letter explains our office policies. Please take time to read, sign and return it to us when you come in for your visit.

**OFFICE POLICY RELATING TO PAYMENT PROCEDURES**

We do expect full payment, including amount(s) not covered by insurance, for services at the time they are rendered. We accept:

All major credit cards,

Personal checks (a \$25.00 fee will be charged for any returned check.)

Cash

Care Credit – a convenient, low minimum monthly payment program also offering 3,6, or 12 Month No Interest Payment Plans.

[www.carecredit.com/dentistry](http://www.carecredit.com/dentistry)

Insurance Patients: Our records are only as accurate as the information provided by the patient. We request you notify us immediately as to any change to insurance and/or employer status. This office will submit **one** claim per service date to your specified insurance carrier. In the event the claim is denied, the patient will be responsible for full payment to us and may then privately seek insurance reimbursement.

**\*Associated Dental Group is an In-Network Provider for most Delta and Blue Cross/Blue Shield dental insurance plans.**

**\*\*Please note: This office no longer accepts new subscribers to Aetna or Cigna DMO / DHMO dental insurance plans.**

**OFFICE POLICY RELATING TO CANCELLED AND/OR BROKEN APPOINTMENTS.**

We realize everyone experiences a busy lifestyle and so, have established office hours to meet those needs. In addition, we make every attempt to afford each patient one or more reminders as to upcoming scheduled hygiene appointments. Therefore, in the event a patient cancels without adequate notice - **72-hours (3 Business Days)** as required by this office - OR fails to appear, they may be responsible for a cancellation fee of up to the full amount of the visit.

**FINANCIAL AGREEMENT**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees for services rendered to a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

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Signature of Parent, Guardian or Personal Representative

Date

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Please print name of Parent, Guardian or Representative - Relation to Patient