OFFICE POLICIES

APPOINTMENT REMINDERS

Please understand that it is **your responsibility** to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment.

CANCELLATIONS

Due to a continuous high demand in prime appointment times, we require a **minimum of 2 business days** advance notice to cancel or reschedule an appointment. This is time that the Doctor and staff have reserved specifically for you. If adequate notice is not provided on two or more occasions, a prepaid **fee of $50** will be required to reserve a future appointment date.

DIRECT BILLING INSURANCE & PAYMENT ARRANGEMENTS

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility** to know the details involved in your plan such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies, please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. **Copperstone Dental** can also provide estimates when requested so you may budget your finances accordingly.

Copperstone Dental is pleased to offer you the following payment options. Please **CIRCLE** which option you would like to participate in.

Option A

INSURANCE WILL BE PAYABLE TO THE PATIENT

Payment is due **in full** the day of treatment is completed. We accept Cash, Visa, Debit and MasterCard. Your payment will be processed & insurance documents will be generated for you to submit to your insurance carrier. An insurance cheque will be sent directly to you from your insurance carrier.

Option B

WE DIRECT BILL TO INSURANCE – PAYMENT IS PAYABLE TO THE DENTIST

You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion. If we receive an explanation of covered costs from your insurance company at the time of your visit, you will be required to pay the outstanding balance before you leave.

I have read & understood the above policies.

_____ _____

Patient/Guardian Signature Date

For **Option B only:**

I heareby authorize any outstanding balances not covered by my insurance carrier to be automatically applied to:

Card #: _____/_____/_____/_____ Expiry Date :_____(mm/yr) **VISA** **MASTERCARD**

Name **(on credit card)**_____

Signature of Cardholder:_____

Receipts will be emailed to the following address: **Email: _____** **(if requested)**