FOR ALL PATIENTS TO READ:

PAYMENT POLICY:

1. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
2. FOR PATIENTS WITH INSURANCE: ANY CO-PAYMENT AND DEDUCTIBLES ARE ALSO DUE ON THE DAY SERVICES ARE RENDERED. (WE CALCULATE THESE TO THE BEST OF OUR ABILITIES, THERE MAY BE AN ADDITIONAL CHARGE AFTER THE INSURANCE HAS PAID-AS WE HAVE PREVIOUSLY STATED, THIS IS ONLY AN ESTIMATE).
3. IF YOU HAVE ANY QUESTIONS OR NEED ANY ESTIMATES, PLEASE FEEL FREE TO ASK US AT ANY TIME.
4. **PATIENTS ARE RESPONSIBLE FOR ANY BALANCE ON THEIR ACCOUNT.**

PLEASE NOTE: FOR PATIENTS WITH INSURANCE: IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN. AS A COURTESY, OUR OFFICE TRIES TO INFORM PATIENTS IN ADVANCE OF ANY CO-PAYMENTS THAT MAY BE DUE. HOWEVER, WE ARE NOT ALWAYS ABLE TO DISCUSS THIS WITH THE PATIENT BEFORE THEIR VISIT.

IF YOU ARE UNSURE OF CO-PAYMENT/PAYMENT DUE, PLEASE ASK!!!!

PATIENT SIGNATURE:____**DATE:** ___________________________

********IF PATIENT IS UNDER 18 YEARS OLD, PARENT/GUARDIAN SIGNATURE IS REQUIRED********

MEDICAID MANAGED CARE PLANS ONLY FINANCIAL STATEMENT:

AT WESTSIDE DENTAL WE ENSURE THAT ALL INSURANCE ELIGIBILITIES ARE CHECKED PRIOR TO SERVICES BEING RENDERED. IF YOU ARE NOT ELIGIBLE AT THE TIME OF SERVICE, WE WILL INFORM YOU OF THIS AND ALLOW YOU TO:

1. PROVIDE UPDATED INSURANCE INFORMATION OR
2. RESCHEDULE YOUR APPOINTMENT TO ALLOW TIME FOR YOUR INFORMATION TO BE UPDATED.

AT TIME THOUGH, A PATIENT'S ELIGIBILITY IS NOT UPDATED BY THE INSURANCE COMPANY UNTIL AFTER SERVICES ARE RENDERED, THIS HAS RESULTED IN TREATMENT BEING RENDERED TO PATIENT'S THAT DID NOT HAVE ACTIVE INSURANCE COVERAGE AT THE TIME OF SERVICE. IT IS THE RESPONSIBILITY OF THE PATIENT TO MAKE SURE THAT THEIR COVERAGE REMAINS ACTIVE; THEREFORE, WE WILL BE BILLING PATIENTS FOR SERVICES RENDERED WHEN COVERAGE WAS NOT ACTIVE. IT WILL THAN BE RESPONSIBITITY OF THE PATIENT TO PAY FOR THE SERVICES OR TO PROVIDE WHATEVER INFORMATION IS NEEDED TO THE INSURANCE TO RE-ACTIVATE YOUR COVERAGE. WE WILL BE HAPPY TO RE-SUBMIT ANY CLAIMS IN THESE CIRCUMSTANCES.

I, THE UNDERSIGNED, UNDERSTAND THAT MAINTAINING THE STATUS OF MY INSURANCE IS MY RESPONSIBILITY. I ALSO UNDERSTAND THAT IN THE EVENT THAT MY COVERAGE ACTUALLY TERMINATED PRIOR TO SERVICES BEING RENDERED, I AM RESPONSIBLE FOR THE BALANCE IN FULL.

PATIENT SIGNATURE:____**DATE:** ___________________________

WESTSIDE DENTAL 50 AUERT AVE. UTICA NY 13502 PHONE: 315-266-0000

Attendance Policy

PLEASE BE ADVISED THAT WESTSIDE DENTAL HAS A STRICT ATTENDANCE POLICY

-IF YOU NEED TO CHANGE OR CANCEL YOUR APPOINTMENT YOU MUST CALL OUR OFFICE 48- HOURS BEFORE YOUR SCHEDULED APPOINTMENT.

-IF YOU CANCEL AN APPOINTMENT ON THE DATE OF THAT APPOINTMENT OR IF YOU DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT YOU WILL BE CONSIDERED AS A NO SHOW.

-REPEATED NO-SHOWS WILL RESULT IN DISMISSAL FROM OUR DENTAL PRACTICE AT THE DISCRETION OF MANAGEMENT.

-IF YOU ARE DIMISSED FOR REPEATED NO SHOWS, YOU WILL NOT BE ABLE TO RETURN AS AN ACTIVE PATIENT OF WESTSIDE DENTAL FOR A PERIOD OF NO LESS THAN ONE YEAR. REPEATED NO SHOWS AFTER BEING REINSTATED AS AN ACTIVE PATIENT WILL RESULT IN PERMANENT DISMISSAL FROM OUR DENTAL PRACTICE.

PATIENT'S SIGNATURE:____DATE: ___________________

Consent

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between myself and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient/Guardian signature:____Date: _________________