A.I.R. Dentalplex
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# Written Office Policy

*We are committed to providing you with the best possible care. In order to better serve you, we have outlined our policies related to scheduling and office operations. Please read the following carefully.*

**Please inform the office if there are any changes in your health, medications, home/mailing address, phone number, email address or insurance.** We ask that you provide us with as many ways to contact you as possible, including an emergency contact person.

Notification of an appointment change must be made during regular business hours within 24 hours of appointment time. In the event of multiple cancellations or broken appointments, **we reserve the right to charge a missed appointment fee of $50.**

In the event of an after hour emergency visit, there will be a fee of $175.00 that will not be billed to your insurance and will be collected at the time of service. The emergency fee is in addition to the treatment that is performed.

**Copayments, coinsurance and deductibles are due at the time services are rendered.**

For your convenience, we accept cash, checks, Visa, Mastercard and Discover. For larger treatment plans, CareCredit and Lending Club are available. **A fee of $35.00 will be assessed for any returned checks.**

After payment has been received from the insurance company, the patient is responsible for any balance owed on their account. Any balance older than 90 days may be subject to interest charges of 15% per month.

Patients with delinquent accounts that go to a collection agency will be responsible for the amount of their bill plus the cost of the collection agency along with any legal fees.

I UNDERSTAND I MUST ADHERE TO SEMI-ANNUAL CLEANINGS AND EXAMS. MISSING SEMI-ANNUAL CLEANINGS WILL VOID ANY WARRANTY ON DENTAL WORK COMPLETED BY DR BORODATY (including but not limited to: composite fillings, posts, crowns, implants, partials).

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read and understand all of the information above.

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PATIENT SIGNATURE DATE