Jackson & Joyce Family Dentistry

Scott A. Jackson, DMD *Joseph C. Joyce, DMD*

Welcome to our Dental Practice! We look forward to taking care of your future dental needs. As a patient of Jackson & Joyce Family Dentistry, we would like to inform you of our office policies. The following policies have been enacted to enable us to continue to provide the highest quality dental care to our patients. We value our relationship with our patients and will be happy to assist you with our policies and charges.

We take pride in giving each patient our undivided attention while receiving services at Jackson & Joyce Family Dentistry. In order to do this we request you arrive promptly to all your appointments. If you arrive greater than 10 minutes late we may have to reschedule your visit. **A cancellation fee will be applied for broken or missed appointments unless 24 hour notice is given.______ (Initial).**

Patients without Dental Insurance

All payments for services are due on the day the services are performed. A service charge may apply if payment in full is not received. **Outstanding balances past 30 days will incur a 1.5% finance charge monthly ______ (Initial).** We make every attempt to contact you to collect delinquent balances prior to proceeding with collections.

Patients with Dental Insurance

We understand dental insurance can be confusing. We have prepared some information you may find valuable. One common misconception is that dental insurance was designed to pay for all your dental care. The treatment recommended by Dr. Jackson and Dr. Joyce is never based on what your insurance company will pay. We ask you to also be familiar with your insurance maximum and benefits.

All levels of payments by insurance companies have nothing to do with the actual charge for the dental care you receive. Our fees are based upon a combination of our costs, our time and our constant dedication to supplying our community with the highest quality dental care.

Insurance estimations made by our office or by your insurance company are just that an **ESTIMATE** and is not a guarantee of payment. **It is the patient's responsibility to pay deductibles and co-payments at the time services are received_______ (Initial). Outstanding balances not paid by insurance past 30 days will incur a 1.5% finance charge monthly ________ (Initial).**

Our office files primary dental claims as a courtesy for our patients. However, it should be understood that the dental insurance contract is between the insurance company and the patient. If we have knowledge that your insurance company sends payments to you rather than our office you will be required to pay for the entire treatment in full at time of service. **If your insurance has not paid your dental claim within 60 days you will be responsible for the entire payment _____ (Initial).**

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Patient or Parental Guardian Signature *Date*