OFFICE INFORMATION

Insurance Information

There is no direct relationship between our office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits; **dental insurance policies vary.** While it is your responsibility to understand your insurance policy, we will do what we can to help you understand and maximize your insurance benefits.

We ask that you be responsible for the payment of **emergency visits, examinations, consultations, biopsies, radiographs, and maintenance (cleaning) visits.** The office will submit your insurance claim so that **your insurance company may reimburse you.**

We will accept **payment directly from your primary insurance company** for other **commonly covered** periodontal treatment(s) rendered. Prior to treatment, our office will attempt to contact your insurance company to estimate/determine available benefits. This will inform our office what your insurance company is **estimating** to cover. This is only an **estimate of benefits**, and not a guarantee of payment. We suggest that you call your insurance company to verify benefits as well. **You will be responsible for payment of the balance not covered by your *primary* insurance (your co-pay) at the time treatment is rendered.** If financial arrangements for the patient's portion of the fee are necessary, they must be arranged ***prior*** to treatment. After 45 days, any unpaid balance not covered by your insurance company (including delays in insurance company payment/processing) will be billed to you and is due within 15 days.

Overdue accounts (balances due over 60 days) will be charged finance charges of 1.5% monthly (18% annually). Overdue/unpaid accounts will be subjected to collections actions. The patient or guardian will be responsible for collections agency, attorney, court and all associated fees incurred by Dr. Paul C. Kazmer, Jr., DMD,MS,PA if collection actions are necessary.

Insurance/Communication Authorization/Scope of Care

I authorize the release of any information contained in my dental files for the purpose of y treatment, billing and processing of insurance claims. I permit a copy of this signature, **if needed**, to be used in place of the original on all my insurance submissions. In addition, I authorize release of any information contained in my dental files to the/my referring dentist(s) and/or treating dentists and/or physician(s). Also, I authorize my medical physician to release any or all information/lab work that is pertinent to my dental treatment with Dr. Kazmer. I understand that it is my responsibility to seek care with a restorative dentist who will diagnose and treat restorative and/or other dental treatment needs. My treatment with Paul C. Kazmer, Jr., DMD,MS,PA is limited to periodontal and/or dental implant concerns.

Broken Appointment Policy

Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify us at least **48 hours in advance.** As a courtesy to you we will attempt to confirm your appointment, but it is your (or guardians) sole responsibility to keep and confirm scheduled appointments. **Broken appointments, late arrival (more than 15 minutes after your scheduled appointment) requiring rescheduling and appointments cancelled with less than 48 hours notice will be charged $100 per appointed hour. Surgical deposits *will be forfeited* if you arrive late or do not show for your scheduled appointment.**

Office Fee Policy

A fee of $25 will be charges for insufficient funds/returned checks. After examination an initial treatment plan will be established and fees will be reviewed. During treatment, unexpected situations may be discovered. The actual fee(s) charged will depend on services rendered in order to correct periodontal/other destruction/damage/defects/disease.

I understand and agree to these office guidelines.

Signature of responsible individual:

X____ Date____________________________