

Sinquefield Family Dentistry
Dr. Jess Sinquefield
522 A Brandies Circle
Murfreesboro, TN 37128

OFFICE POLICIES

I understand and give my permission to Sinquefield Family Dentistry to perform diagnostic services to help better determine the appropriate treatment needed for my proper dental care. These diagnostic services may include any or all of the following: x-rays, oral examination, biopsy, periodontal evaluation, probing, or any other necessary service to help Sinquefield Family Dentistry make an adequate diagnosis.

Once a diagnosis is made, I will be given a treatment plan. The purpose of this plan is to make me aware of the recommended treatment, the estimated cost of the recommended treatment and the anticipated financial responsibility of the recommended treatment. I understand that once the treatment is performed, if my insurance company denies the treatment, or if they pay less than expected, than I am responsible for any remaining balance. Furthermore, I understand and agree that my estimated portion of any and all treatment will be paid upon the day of service. Forms of payment include Visa, Mastercard, American Express, Discover, Check, Care Credit and Cash.

As a courtesy, Sinquefield Family Dentistry will file a Pre-Estimate, at my request, for any recommended treatment to help me better determine what I can expect my portion to be. Additionally, as a courtesy when treatment is performed, Sinquefield Family Dentistry will file my insurance for payment. However, I understand and agree that if my insurance company fails to pay within 30 days, or if they pay less than expected, then I become immediately responsible for the balance remaining and will pay such balance upon receipt of statement.

I understand that a service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on my account should it exceed 30 days, unless previous written financial arrangements are satisfied. If my delinquent account results in collection proceedings, then all additional collection costs, court costs and legal fees will be paid by me.

Sinquefield Family Dentistry reserves time, personnel and facilities just for me when I have an appointment scheduled. I understand and agree that Sinquefield Family Dentistry requires a 24 hour notice in advance of my scheduled appointment to avoid a \$50.00 cancellation fee per appointment.

I grant my permission to Sinquefield Family Dentistry to telephone me at home, work or cellular phone to discuss matters related to my treatment, financial obligations or appointments.

Signature of Patient

Date

Signature of Parent if Patient is a Minor

Date