Welcome to Legends Dental

Dr. George Jedlicka, DMD

Thank you for choosing our practice. Our office takes pride in providing the highest quality oral health care. In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information.

OFFICE POLICIES:

INSURANCE: You are responsible for payment in full. We will bill your insurance as a courtesy to you. Insurance is not a guarantee of payment. Deductibles and your estimated co-pays will be due at the time of treatment. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment**.** We will happily bill both primary and secondary insurance companies. However, if you do not present insurance information at the time services are rendered, you will be responsible for billing your own insurance company.

PATIENT PAYMENT: We accept cash, Visa, MasterCard, American Express, personal check, and CareCredit cards. Returned checks will have a $25.00 fee added to the total payment due.

SERVICE CHARGE: If payment for services rendered has not been paid in full within 60 days either by you or your insurance company, the remaining balance for treatment is considered past due and an interest rate of 10% will be charged.

NO SHOW/ MISSED APPOINTMENTS: We request notice of 24 hours for cancellation of appointments. We reserve the right to charge a $50.00 fee for missed appointments without sufficient notice. We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office coordinator.

I have read, understand, and agree to the above terms and conditions. I certify that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist/dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. By signing this form, you are authorizing payment directly to our office by your insurance company. This form will also authorize the release of any information, including the diagnosis and records of treatment or examination rendered, to your insurance company.

PATIENT SIGNATURE:_____DATE:_____