Office Policies and Financial Agreement

Dr. Abenaa Ayeh
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Office policies and Financial Agreement

It is our desire to provide the highest quality dental care to everyone. The following is a statement of Dr. Ayeh's office/financial policies. We ask that you please read, agree to, and sign before any treatment is rendered.

Regarding Insurance

Our goal is to maximize your insurance benefits. It is important to understand that the insurance contract is between the insurance company and you, the insured. Dental insurance was not designed to pay for all dental care. Treatment recommended by Dr. Ayeh is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balances remaining on a yearly maximum.

Please be prepared to show your insurance card at the time of your visit. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient/guarantor is responsible for the estimated portion of what the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made a payment within 30 days, the patient/guarantor is responsible for the balance in full. _____ (initial)

Payment options

Cash, Cheque, Debit, MasterCard, Visa, or American Express

3rd Party Financing

With prior approval, we are pleased to offer a choice of No Interest or Extended Payment Plans to qualified applicants. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form.
_____ (initial)

Collection accounts

If for some unforeseen reason your insurance carrier has denied or not made a payment within 30 days, the patient/guarantor is responsible for the balance in full, and the payment option selected by the patient will be charged at the end of this 30 day period as necessary. In the event that any cheques/payments are returned, a service fee of $40.00 will be applied to the patient's account in addition to your bank's fees for processing, and the patient will be notified to set up an alternative payment method. If the payment has not been received from the patient within 60 days after completion of treatment a statement will be sent, along with a notice of collection.

If after two notices of collection the account has not been paid in full, the patients account will be sent to a Collection Agency to arrange payment. _____. (Initial)

Addition charges

A fee of $40.00 will be charged on all returned cheques/payments. _____. (Initial)

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two-business days' notice. Our office does not accept cancellations or changes in appointments after hours by voice mail; you ***must*** call during our normal business hours. This courtesy of your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. A fee of $150.00 will be charged onto the patients account for a missed appointment. _____ (Initial)

Office Hours:

Monday:	8:30am – 5:00pm
Tuesday:	8:30am - 7:00pm
Wednesday:	12:00pm - 8:00pm
Thursday:	11:00am – 7:00pm
Friday:	8:30am – 5:00pm
Saturday:	The office is open a couple of Saturdays per month by request, please call the office to find out which ones as it is subject to change.

_____ _____

PATIENT SIGNATURE (Parent/guarantor if patient is a minor) ***DATE***

_____

CHILD'S NAME