

## Office Policies

Thank you for choosing Meadow Creek Family Dental as your dental provider. We are committed to providing you with the best dental treatment. The following is a statement of our office policies, which we require you read and sign prior to any treatment.

**Payments and co-pays are due at the time of treatment unless prior arrangements have been approved.**

### **Insurance Claims:**

We will gladly process insurance claims for you. Most insurance companies do not cover all charges at 100% and your estimated co-pay and deductible are due at the time of service.

### **Usual and Customary Fees:**

This office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

### **Minor Patients:**

Non-emergency treatment will be denied for unaccompanied minors. The approval of a parent or legal guardian is required before any treatment can be given. The adult accompanying the minor at the time of service is responsible for paying for that treatment.

### **Cancellations and Missed Appointments:**

If a weekday (Mon-Fri) appointment needs to be cancelled or rescheduled please give us **48 hours notice**. We charge **\$60** without sufficient notice. This makes up for the hour that was saved for the planned procedure. If a Saturday appointment needs to be rescheduled we will charge **\$100 without prior notice**.

### **Delinquent Accounts:**

Any account that is unpaid for over 90 days will acquire 1.5% interest each month. If we are working to get the balance paid by an insurance company, we will write off the charges.

### **Transferring or Duplicating Records:**

We are required to keep original records and x-rays in our office for 7 years by Washington State Law. If you need a copy of your x-rays we charge \$20. Copies of records are free of charge.

Thank you for understanding. Please let us know if you have any questions.

Patient or Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_