



Office Policies

No Show Policy

We expect patients to be present at all scheduled appointments exclusively reserved for them. To avoid a \$50 missed appointment/late notice fee, 48-hour notice is required. This fee must be paid before being scheduled again.

Missed Appointments

After two "No Show" appointments (missed appointments without 48-hour notification) you will be subject to dismissal from our practice.

Late Arrivals

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. Late arrivals of greater than 15 minutes risk not being seen. We will try to accommodate late appointments as time permits; however, those patients who are here at their assigned time will be seen first.

Financial Policy

For those without insurance, full payment is due at the time of service, regardless of who accompanies the patient on the day of his/her appointment. For those with insurance, we file claims as a courtesy to our patients and we gladly accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out of pocket expenditures. However, we will collect the estimated portion of your fee at the time that services are rendered. Keep in mind that this is only an estimate - if there is any difference after your insurance pays, we will contact you and make the proper adjustments.

You are responsible for the timely payment of your account. If your insurance company has not paid your claim in full within 30 days, you will be notified so that you can discuss the matter with your insurance company. If the claim is not paid within 45 days, the balance and all follow-up with the insurance company becomes your responsibility and all remaining balances will be charged to your credit card on file.

Credit Card: Visa/MC/AMEX/Disc # _____ EXP: _____

It must be stressed that your insurance is a contract between you, your employer, and the insurance company. Please contact your insurance company prior to your first visit to ensure you have coverage with our office and to review your benefits.

We accept cash, checks and credit cards.

Thank you for reading our Office Policies. Please let us know if you have any questions or concerns. We appreciate the trust and confidence you have placed in us for your child's dental care.

I have read, understand and agree to abide by the Office Policies of Twinkle Little Star Pediatric Dentistry, LLC:

Print Name: _____

Signature: _____ Date: _____