Dental Partners of Newburyport
www.dentalpartnersofnewburyport.com

# Office Policy

Thank you for choosing our office for your achieving and maintaining dental health. We are committed to the success of your dental treatment and want to provide you with the best service available. In order to maintain operation of our office in the highest standard of comprehensive care, it is necessary to collect payment for services when treatment is rendered.

Please choose one of the following:

- I will bring a check or cash to each appointment to pay for the services performed that day. I understand I may not be treated if payment can not be collected on the day of treatment.
- I will use a major credit card for the services performed at each visit or for the portion my dental insurance does not cover.
- For treatment amounts over $300, I am interested in the possibility of an extended payment plan.

- **To patients with dental insurance:**

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is delivered to you, your co-payment will be expected at that time. If your insurance company fails to pay within 30 days after we submit your claim, you will be responsible for the full fee.

- **To all patients:**

We request **48 hours** notice for any appointment change. It is our policy to charge a fee for any appointment that breaks these criteria. A broken appointment is one that you either do not show up for or do not cancel prior to 48 hours of your scheduled appointment. If your appointment was scheduled for a Monday you must cancel your appointment by Thursday of the previous week, as we do not have office hours Friday. We do **not** accept cancellations left on our answering machine. *Such policies are standard practice for health care providers who work one-on-one with patients.*

**Acceptance Agreement**

I understand and agree with the above office policy. I understand that the parent, relative, or anyone else bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient/Responsible Party: ______________________________
Printed Name

______________________________ ______________
Signature Date

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