DENTISTRY
ON AIRPORT

391 Airport Rd, North Bay, Ontario P1B 8W8 Tel:(705)-472-1771 Fax:(705)-472-1779 www.DentistryOnAirport.ca

Financial Guidelines & Broken appointments Policy

Name: _____ **Date:** _____

Type of card: Visa ☐ Mastercard ☐

Name on Card: _____

Card #_____Expiration: _____/_____ CVV:_____
(# on back of card)

Card holder Signature: _____

Check the option you agree to:

☐ **Option 1 – No Insurance**

All payments are due in full at each appointment.

☐ **Option 2 – You have Insurance but want Non – Assignment**

We submit claims to your insurance on your behalf. You will be reimbursed directly.

Full payment is required at the time of each appointment.

☐ **Option 3 – You Have Insurance and want Assignment – CREDIT CARD REQUIRED**

This option allows insurance to pay Dr. Patel directly. We submit your claim, and you pay only what is not covered. A copy of a government piece of photo ID and credit card is required.

Please note:

You are responsible for any service fees or balances not covered by your insurance plan.

Treatment options are determined by your needs, not your benefits coverage.

Balances not covered will be charged directly to your credit card on file.

If you fail to update your credit card information as needed you will lose this courtesy option and will be required to pay in full upfront at each appointment.

_____
Initial

Financial responsibility for all family members on this card: **Yes** ☐ **No** ☐

I acknowledge that I am financially responsible for all fees associated with dental services provided to all family members listed below. **(ALL MINORS MUST BE LISTED BELOW)**

_____ _____

_____ _____

_____ _____

I _____hereby authorize Dr. Patel's Dentistry on Airport to submit claims on my behalf and agree to assign payment directly to them. I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any fees or balances that may not be covered by my plan and my credit card on file will automatically be charged after 48 hours for any amounts due.

Broken Appointments:

Your appointment is reserved exclusively for you.

If you are unable to keep your appointment, we kindly ask that you provide at least two business days' notice so we can offer the time to another patient.

Failure to notify us may result in a cancellation fee of $100/hour or scheduled time being charged to your credit card on file, which is not covered by your insurance.

I confirm that I have read, understand, and agree to the terms outlined in the financial agreement and the broken appointment policy. By signing or acknowledging this statement, I accept all responsibilities and conditions stated therein.

_____ _____

Signature **Date**