*Dr. Judd Shenk, DMD*

*DRSHENK.COM*

SHENK DENTAL CARE

# OFFICE POLICIES

**Name**_____

## FINANCIAL POLICY

Patients are expected to pay in cash, check, or credit card the day the service is rendered. For patients who are covered by insurance, we will accept assignment of benefits. Most dental insurance plans do not cover 100% of the cost of treatment. Because of this and the delay in receiving payment from the insurance company, we require that you pay your deductible and co-payment on the day the service is rendered. **We will estimate this amount as closely as possible using the insurance information we have; however, THIS IS AN ESTIMATE. Our agreement is with YOU and NOT your insurance company.** We will assist you in working with your insurance company, however the ultimate responsibility lies with you. After sixty (60) days, the balance will be due in full. I understand that a finance charge of 1.5% will be added to my account for charges due over sixty (60) days.

**Signature** _____ **Date** _____

## LATE/MISSED APPOINTMENTS

At our office, we know that your time is valuable and we reserve a time slot just for you to give you the best service possible. For us to keep this level of service, we ask our patients to give us a minimum of 24 hours notice if they can't make it to their appointment.This allows for patients with an emergency to be scheduled into that time. **Please note that patients may be subject to a $75 fee for failed appointments and appointments cancelled without 24 hours' notice. ****Prescheduled treatment appointments that are not cancelled within these guidelines may have a higher fee depending on the type of service that was scheduled.****

**Signature** _____ **Date** _____

## AUTHORIZATION (please read following statement and sign where indicated)

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

** I authorize my insurance company (if applicable) to pay the dentist or dental group insurance benefits otherwise payable to me for the service rendered.

**I authorize the use of this signature on all insurance submissions (if applicable).

**I authorize the dentist to release all information necessary to secure the payment of benefits.

**Signature**_____ **Date**_____

## ELECTRONIC COMMUNICATION AGREEMENT

Shenk Dental Care may communicate with me electronically using the email and/or mobile phone information on file. All account statements will be paperless and sent via email unless requested by mail only. I can withdraw this consent at any time by calling the office @ 770.992.6568

**Signature**_____**Date**_____

## MINOR/CHILD CONSENT

I, being the parent of _____ do hereby request and authorize the dental team to perform necessary dental services for my child, including but not limited to, x-rays and the administration of anesthesia which are deemed advisable by the doctor, whether or not i am present at the actual appointment when the treatment is rendered. I agree to be responsible for payment of all such services.

**Signature**_____**Date**_____