**OFFICE POLICIES**

I understand and acknowledge that I am financially responsible for the services provided for myself or the below named individual, regardless of insurance coverage on the day services are rendered. All fees are due and payable at the time of your appointment. For your convenience, we accept cash, check, MasterCard, Visa, American Express and Discover.

As a courtesy, we accept assignment of insurance benefits, **allowing you to pay your deductible and/or estimated co-payment at the time of treatment**. I understand that my insurance policy is a contract between my insurance provider and myself, not between the insurance company and Murrells Inlet Dental Group. I also understand that insurance policies vary greatly from one policy to the next and that Murrells Inlet Dental Group and staff are not responsible for knowing all the details of my policy. We have no control over insurance company’s payment of claims. Any balance left unpaid by your insurance company 60 days after service is due in full by you. I understand that Murrells Inlet Dental Group is authorized to file my insurance as a courtesy to me. We apply a $50 failed appointment fee with less than 24 hour business notice.

Crowns, Bridges, Dentures, Partials and Occlusal Guards require work from an outside lab for completion of treatment. If you do not return for the delivery of this treatment this amount **will not be refunded** due to the cost of the lab bill, supplies and labor we incurred.

Your account is considered delinquent if there have been no payments in 90 days. If your account falls into delinquency, you agree to pay any and all collection agency charges, attorney fees and court fees.

We provide services on an appointment basis. While we make every effort to be punctual, there will be emergencies or circumstances beyond our control that may delay our appointment schedule. Your patience is appreciated. Please notify the office staff if you have any special needs when you arrive.

I give my CONSENT to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending Dentist or by her supervised staff for diagnostic purposes or dental treatment. I have read and accept the above policies and agree to abide by all terms and conditions as stated.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If patient is a child, parent signature is needed)