Amaze Dental
DeSoto & Cedar Hill Dentist

Appointments

_____ Our patients are seen by appointments. When an appointment is made, doctor time and treatment room is reserved specifically for that appointment. Our office will begin calling you two days prior to your appointment to confirm the time. It is our policy that we must speak to you or a parent if the patient is a minor. If a message is left, you must call back 24 hours prior to the appointment to secure your appointment in our office. We will allow messages to be left on our recorder confirming the time if it's after hours.

Insurance

_____Your insurance coverage is a contract between you and your insurance carrier. Our office verifies all insurance coverage and accept assignment of benefits as a courtesy to our patients. We are only able to provide you with an estimate of your benefits based on information received from your insurance company. In the event that your insurance company does not pay their estimated portion of your treatment, you are responsible for payment.

_____ Your deductible, co-pay, and any portion of your treatment not covered by insurance, is due and payable at the time of service. After each appointment, you will receive a walkout statement outlining the charges for that appointment, and any payments made. After our office has received final payment from your insurance company for your treatment, you will be billed for any unpaid balance remaining on your account.

_____ Regardless of insurance status, you are responsible for payment of all treatment fees (covered or non-covered) and any cost, legal or otherwise, which are incurred in the collection of your account balance should become delinquent.

Privacy Notice

_____ I acknowledge that I have been given the opportunity to review and receive a copy of the privacy notice.

Payment of fees

_____ Payment for professional services is due at the time service is rendered, unless you have made prior written arrangements. Payments may be made in the form of cash, check, American Express, Discover, Visa or MasterCard. By signing below, you are accepting responsibility for the payment of any charge incurred in your treatment.

Payment Plan

_____ We do offer financial help through Care Credit.

Responsible Party Name _____ Signature _____ Date _____