Magnolia DENTAL

WWW.MYMAGNOLIASMILE.COM

11 Medical Drive
Chillicothe, OH 45601
740-775-8050 ph 740.775.8053 fax

Welcome To Our Practice! Serving You Exceptional Care with Southern Hospitality

Practice Financial Policy

We are committed to providing you and your family with the best possible care and are pleased to discuss our professional fees with you at any time, and your insurance coverage, with you at any time. Your clear understanding of our financial and insurance policies is important to our relationship. Please ask us, at any time, if you have any questions about this policy.

- All patients must complete and sign the Patient Registration and History form before seeing the Doctor.
- We accept most insurance plans and will gladly process your claim. Please notify us of any changes in your insurance plan and bring your current insurance card to each visit. Insurance policies generally cover only a portion of the total treatment cost. *Unless other arrangements have been made, we ask that you pay your portion of the bill at the time of treatment. It is your responsibility to pay any balance not paid by your insurance company.*
- For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and American Express. Financing is also available through Care Credit.
- Twenty-four hour notice is required when re-scheduling or canceling an appointment. A cancellation fee of $25.00 may be assessed for broken appointments with less than twenty-four hour notice.
- Treatment plans may change, and you will be responsible for the treatment actually completed.
- For your convenience, this office may release your information to your insurance company, and receive payment directly from them. Every effort will be made to help you with your insurance, however, the insurance company, not our office, determines the dental benefits that you receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I am responsible for payment regardless of insurance company's arbitrary determination of reasonable and customary rates. I understand that payment is expected when services are rendered unless other arrangements are made in advance. I have been given a copy of the HIPAA or have viewed the CASEY presentation of the HIPAA information.

Patient Name _____ Birthdate ___/___/____

_____ Date: _____

Signature of Parent or Guardian