jp dental
family cosmetic implant dentistry

General Office Policies

Financial Policy

Our primary goal is to provide you with the best dental care. If you have dental insurance, we will strive to maximize the benefits your plan provides. If there is a balance remaining, or if you do not have insurance, we will make all remaining charges as affordable as possible. Our office uses the best materials and latest technology, and our fees are what is usual and customary for our area.

Please read and initial next to each statement below:

____ I am responsible for all charges at JP Dental Hartford regardless of dental insurance benefits . JP Dental Hartford will file all insurance claims on my behalf, will follow all regulations and requests from my insurance company, and will deduct all payments received from my insurance from my account, but all remaining charges are my responsibility and I will pay them in a timely manner.

____ I will be provided an estimate of charges and what my insurance plan will cover, but this is *not a guarantee* that my insurance company will pay exactly as estimated. I understand my insurance company imposes many limitations, exclusions, waiting periods, frequency limits, age restrictions, etc which affect the amount that will be paid on my behalf. As a result, what my insurance pays may be different than what was estimated by JP Dental Hartford and I am responsible for the balance.

____ Insurance plans typically take 30-60 days to make payment after a claim is submitted. If your insurance has not made payment within 60 days, we ask you call your insurance to verify insurance payment is expected. If payment is not received within 60 days or your claim is denied, you will be responsible for paying the full amount at that time.

____ All insurance deductibles and copays are due at the time of treatment. Non-insurance patients must also make payment for services at time of treatment unless a payment plan or other arrangements have been made such as financing through Care Credit.

____ I hereby authorize payments of dental benefits directly to JP Dental Hartford which otherwise would be payable to me.

____ I will be subject to a $25 fee for returned checks, and $35 monthly late fee for account balances over 90 days

We accept payment via cash, check, credit card, or Care Credit.

Late Notification / No-show Policy

We understand that situations arise in which you must reschedule your appointment, but we do request you provide at least **24 hours notice** of the cancellation. Our practice firmly believes that good doctor/patient relationship is based upon understanding and good communication.

____ I will provide at least 24 hours notification if I must reschedule an appointment. I will be subject to a **$25 cancellation fee** for weekday and a **$50 fee** for Saturday appointments per patient when I give less than 24 hours notice or simply do not show. Exceptions are rare and will be considered on a case by case basis. The fee must be paid at the following appointment before future treatment will be rendered.

____ If I simply do not show for appointments twice, without notification, I may be dismissed from the practice.

I have read and understand the Financial and Late Notification policies at JP Dental Hartford

Signature_____**Date** _____