

# **PATIENT RESPONSIBILITY AGREEMENT**

Daffodil Smiles Aesthetic and Oral Wellness

## **Payment Is Expected At Time Of Service**

For all patients, payment of insurance co-pays, deductibles, and services not covered by insurance are to be paid at the time the service is rendered.

You are responsible for any balances not covered by your insurance, including rejected claims. While every effort will be to submit claims in accordance with insurers' requirements for payment, in the event of a dispute or rejection, you as the insured or guarantor are responsible for payment. Insurance coverage for dental services is a benefit provided to you and the eligible members of your family. The insurance contract is between you and your insurance provider, and not between the insurance company and the dental care provider.

We will be happy to provide you with whatever documentation is necessary to pursue your claim for reimbursement from your insurance company.

## **Payment Responsibility For Divorced/Separated Parents**

The person who brought the child in for service is responsible for payment. This office cannot be responsible for collecting from any other individual.

## **Payment Responsibility for Late Cancellations and Missed Appointments**

We value our patients and their families and try faithfully to respect your valuable time by scheduling at your convenience. With the understanding that extenuating circumstances do occur, we ask you to cancel or reschedule within 48 hrs of a cancellation/missed appointment fee may apply.

When an appointment time is reserved for you, please make it a priority to retain your scheduled appointment. Due to the high demand for appointments, high overhead costs, consistently missed or cancelled appointments cannot be tolerated. There is a \$50.00 fee for missed appointments with the hygienist and a \$80 fee for missed appointments with the Doctor.

The payment is the responsibility of the patient; Insurance does not cover this fee. Failure to comply with this policy may result in dismissal from the office. I acknowledge that I have read and understood this payment policy.

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Signature

Date