WELCOME TO AIRDRIE DENTAL STUDIO

Thank you for choosing our office for you and or your families dental needs.

Please take a minute to read over our office policies:

Appointments:

To cancel or reschedule your appointments we do require 2 business days. This allows us to contact patients who may be waiting for a cancellation. We do understand that extenuating circumstances will not make this possible.

Dental Insurance:

Dental insurance is a contract between you and the insurance company. Due to the privacy act your insurance will not provide us the following information:

1. *Yearly maximums*
2. *Benefit year*
3. *Recall frequency*
4. *Coverage for your proposed treatment*

We will gladly provide any information you may require. We will also provide estimates for all major treatment. And by request estimates will be provided for any proposed treatment. Please be aware of your insurance coverage.

Direct Billing:

As a patient and policy holder you have two options to look after your account.

1. *Pay each visit up front. We will send in the primary claim and secondary claims (if explanation from primary is available) on your behalf and have the insurance direct payment to you. If primary only supplies an acknowledgment the secondary form will be given to you to send in once payment has been received. Insurance companies generally send the payments out within 7-10 business days. Some insurance companies do direct deposit and reimbursement usually occurs within 24-48 hours.*
2. *Assignment from your insurance on your behalf. In order for our office to accept assignment from your insurance we require a valid credit card (Visa, MasterCard or American Express) to be kept on file. This credit card will be used for any balances not known at time of appointment. Receipts are mailed out for all amounts that have been processed on your credit card. Courtesy calls will be made for any balance that was put through that was over $100.00. Payment is required at time of treatment for any amount not covered by your plan.*

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Financial Consent

The patient/ guardian agree to be fully responsible for all treatment provided by Airdrie Dental Studio and not covered by their dental insurance.

Patient name:_______________________________

Patient/ Guardian Signature:__________________________

Date:___________________

Credit Card Information

Name on credit card:____

VISA_____ MASTERCARD______ AMERICAN EXPRESS__________

CARD NUMBER_______________________________________

EXPIRY DATE________________________________

AUTHORIZATION SIGNATURE___________________________________