SK Family Dental Office Policy

At SK Family Dental, we are committed to providing high-quality services and ensuring that appointments are scheduled and maintained efficiently for the benefit of all our patients. To uphold this commitment, we have established the following policy regarding payments and appointment cancellations.

1. Payment Policy

1. **Payment Methods**
   We accept the following forms of payment:
   - Cash
   - Credit/Debit Cards (Visa, MasterCard,Discover, American Express)
   - Care Credit
2. **Payment Due**
   Payment for services is due at the time of the appointment unless prior arrangements have been made.

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2. Appointment Cancellation Policy

1. **Cancellation Notice**
   We kindly request 24 hours' notice for any appointment cancellations or rescheduling. This allows us to offer the time slot to another patient.
2. **Late Cancellations/No-Shows**
   - Appointments canceled with less than 24 hour notice or missed without notice will result in a cancellation fee of $25.
   - Repeated no-shows may require a non-refundable deposit for future appointments.
3. **Exceptions**
   We understand that emergencies and unexpected circumstances can arise. Please notify our office as soon as possible if this is the case, and we will work with you to reschedule without penalty.
4. **Rescheduling**
   Patients who reschedule appointments with more than 24 hour notice will not incur any fees. We will do our best to accommodate your preferred new time.

3. **Notice to Insurance Patients**

1. **Exceeding Insurance Maximums-**
   You are responsible for any charges beyond your insurance plan's annual or lifetime maximums.
2. **Denied Treatments-**
   If your insurance denies a claim, you are responsible for the full cost of the denied treatment.
3. **Delays Due to Missing Forms/Signatures-**
   Failure to comply with insurance requests for forms or signatures may result in delayed or denied payment, for which you will be responsible.
4. **Incomplete Treatment-**
   If you fail to complete your treatment plan, and this causes a denial of payment from your insurance, you are financially responsible for the costs incurred.
5. **Lab Costs from Missed Appointments**
   Missed appointments requiring lab work may incur additional charges, which you are responsible for.

Acknowledgment and Consent

By signing below, I acknowledge that I have read, understood, and agree to abide by the Payment and Appointment Cancellation Policy outlined above. I understand that failure to comply with this policy may result in additional fees or suspension of services.

I further agree that I am responsible for any payments due and will adhere to the guidelines regarding cancellations and rescheduling.

Patient Information:

- **Printed Name:** ______________________________
- **Signature:** ______________________________
- **Date:** ______________________________