OFFICE POLICIES

Financial Policy

Thank you for choosing Mohr Smiles Dentistry. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

- Check, Visa, MasterCard, American Express or Discover Card
  (If bank fees are incurred for a returned check, those fees will be applied to your account)
- Convenient Monthly Payment Options from third party lenders.

As a courtesy for patients with dental insurance, we are happy to submit claims on your behalf.

We use the information given to us by your carrier to estimate your out-of-pocket costs to the best of our ability. Please be advised that this is a courtesy and not our responsibility. In the end, it is your responsibility to understand the contract between you and your insurance carrier. You have the right and responsibility to contact your insurance carrier directly or refer to your benefit plan book to confirm treatment coverage. You may also request that we submit a preauthorization on your behalf. You are responsible for all treatment provided, even if your insurance does not cover the amount we estimated.

If it is necessary to place your account with a collection agency, there is an additional charge of 35% of the principal balance. Should legal action become necessary to collect the balance due, you will be responsible for reasonable attorney's fees, interest and court costs we incur as a result. If your account is placed with an agency for collection, or an attorney for legal action, a credit report may be obtained for the sole purpose of collecting the delinquent account.

Your treatment plan, as presented to you, is based on your current diagnosis. In the rare event that unforeseen issues arise during treatment that indicate minor changes, and it is not feasible to stop to discuss the changes, your dentist will deliver the treatment needed based on your desired outcome and your best interests as circumstances dictate.

Appointment Policy

You may be asked to pay your estimated fees at the time of scheduling your procedure.

We understand that there will be certain circumstances that may require you to change or cancel appointments. However, we ask that you provide us with ***48 business hours***' notice to cancel or reschedule your appointments so that we may provide the opportunity to offer another patient your scheduled time. We reserve the option to charge a fee of $50 per any fraction of an hour scheduled for a failed appointment.

Photo Policy

Photos of your teeth will be taken at your initial exam and occasionally during the course of care. These photos are protected by HIPAA privacy regulations and will be kept as part of your CONFIDENTIAL record.

Only with your permission, and with identifying characteristics concealed, we may wish to use photos for educational and academic purposes.

Please initial below to authorize or decline:

_____ Yes, for educational and academic purposes only (no identifying features shown).

_____ No, you may not use my photos.

By signing below, I signify that I have read, understand, and agree to these office policies.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)