Colonial Heights Dental Group
Susan B. Creech, D.D.S ● Trevor Lawson, D.D.S.

Appointment, Financial and Insurance Guidelines

For the convenience of our patients, the following office policy and financial agreement has been established for your review.

APPOINTMENTS:

Your appointment has been reserved just for you and we encourage all patients to keep their appointments. We provide a reminder service by phone, text, and/or email address, if an email address is provided by the patient. We consider all appointments confirmed when your appointment is scheduled, should an emergency arise that you need to make a change, **please provide at least a 24 hour notice.**

INSURANCE:

Your dental benefits are based upon a contract made between you or your employer and an insurance company. **Depending on your dental needs, dental insurance benefit plans may not cover 100% of your dental care. If you have any questions regarding your dental insurance benefits please contact your employer or insurance company directly.**

We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**.

We require payment of your **estimated** portion at the time of treatment. We will bill your insurance to maximize your benefit. It may take several weeks to receive payment from your insurance company. Once final payment has been received a statement of the remaining balance, if any, will be sent to you. We request that payment be made in a timely manner to avoid late fees or collection activity. You are ultimately responsible for what your insurance will not provide: deductibles, co-insurance, and non-covered expenses.

PAYMENT POLICIES:

We accept Cash, Check, Visa, MasterCard, Discover, and American Express. We also accept LendingClub as payment. If approved, LendingClub offers 12 months no interest financing on services over $4000. An application for LendingClub approval can be submitted in office and will have a response within just a few minutes.

I, _____, understand and agree to the appointment and payment policies for Colonial Heights Dental Group. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____
Signature(Patient or Responsible Party) *Date*

_____ _____
Office Representative *Date*