Crab Orchard Dental Center
Michael L. Smith, DDS
1271 Robert C. Byrd Drive
Crab Orchard, WV 25827
Phone (304) 253-4473
www.craborcharddentalcenter.com

Office Policy

Dr. Michael Smith and his staff are pleased to welcome you as a new patient. Our mission at the Crab Orchard Dental Center is to provide the best comprehensive dental care possible in a relaxed and pleasant atmosphere. We also try to keep the cost of your dental care investment as easy and manageable as possible.

To assist you with your cost of dental care, we provide the following payment options:

1. Cash – includes money orders and personal checks
2. Visa / Mastercard / American Express / and Discover
3. Care Credit – payment plans that allow you to pay overtime with convenient low monthly payment, usually interest free. *** subject to credit approval
4. Most dental insurances accepted

We are happy to offer these choices so that you can select a payment option that best fits your needs. Payment is due at the time dental service is rendered. If you have dental insurance, your patient share is due at the time service is rendered. You are responsible for any non-covered items or services. Your dental benefits are based upon a contract between your employer and the insurance company or plan your employer chose. If you have any questions regarding your dental benefits, please contact your employer or the insurance carrier directly. Dental benefits differ greatly from medical benefits. In 1962, most dental plans had a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 40 years! The majority of dental plans today have an average maximum cap of only $1,500 even though there has been significant increases in your premiums. Dental benefits will never fully pay for completion of your dental care. It has always been meant to assist you. Our decisions for your comprehensive dental treatments are based on your dental needs and what we feel will serve you best. Our decisions for your dental services are not based on your insurance coverage. _____ initial

BALANCES: Sometimes after insurance reimbursements, patients are left with balances. If this happens, we will send you a statement. If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 60 days, your account will be assessed a finance charge of 1.5% per month. If your account is turned over to a collections agency, a collection fee (currently 40% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major

credit bureaus. If, for any reason, the account is litigated, the patient is responsible for all attorney and court fees. _____ initial

REFUNDS: Overpayment will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been pain in full. _____ initial

RETURNED CHECKS: There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order or cash. We will not schedule any other appointments until this fee is paid. Once a check has been returned, this office will no longer accept personal checks for payment. _____ initial

MISSED APPOINTMENT: In consideration to all of our patients, we see patients by appointment only and make every effort to be on time. In emergency situations we ask that you kindly give us a call before coming in. If for some reason you are unable to keep your scheduled appointment, please call or email mlsdds1@frontier.com prior to 24 hours of your appointment. With this notice, we can reschedule your appointment and let another patient have the appointment time originally scheduled for you. There will be a $50 fee for cancellations made without 24 hour notice and for failed appointments ("no shows"). The $50 will be posted to your account. This amount is not covered by your insurance company, and will be the sole responsibility of the patient. You will not be allowed to make any other appointment for yourself or your family members until it is paid in full. _____ initial

We appreciate your understanding of this policy. We look forward to continuing to serve you and your family's dental health needs.

I have read and understand the above.

_____ Date_____

PATIENT SIGNATURE (if patient is a minor, parent or guardian sign)