Welcome!

Thank you for coming to the Southside Dental Clinic

We would like to take this opportunity to welcome you! The purpose of the following information is to provide you with our office policy of patient care.

Appointments:

- Please be on time for your appointment. This enables us to stay on schedule. If you are late for your appointment, you may be rescheduled or dismissed at our discretion.
- We ask that you please notify us 24 hours in advance for any change in appointments. If you fail to come to your scheduled appointment, we reserve the right to terminate any further treatment.

Payment of Services:

- We accept the following forms of payment: Cash, Check, Visa, Mastercard, Discover, American Express.
- Financing is available from CareCredit to cover treatment costs and make monthly payments with 0% interest. Ask front desk staff how to apply.
- Payment is due at the time services are rendered.

Insurance Policies:

- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will accept assignment of benefits from your insurance company. However, any and all charges not paid by your insurance company will be your responsibility.
- We will make every effort to provide you with the most accurate estimate of insurance benefits and out-of-pocket costs for your treatment with the information you provide to us. However, actual insurance payments may differ and you may wish to have us send a pre-treatment authorization to your insurance company. This information may take 2-3 weeks to process.
- All insurance co-pays and deductibles must be paid at the time of service.

Financial Responsibility:

- A reasonable administrative or collection fee will be added to the amounts due and owing more than 90 days from the date of the initial transaction. The undersigned agrees to be responsible to pay for reasonable collection fees for any services rendered that enter a default status
- PLEASE NOTE: We will gladly accept your personal check as form of payment. If however, your check is returned unpaid by your financial institution for any reason, you will incur an additional $27.50 fee.
- I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I have read, understand, and agree to the office policy.

- Signature of patient/responsible party:____ Date:________________