FIFE DENTAL CARE

Office Policies & Patient Authorizations

Appointments

Our practice is dedicated to quality care and exceptional service. Our providers and staff spend extensive amounts of time preparing for your visit. Broken and missed appointments created scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of two (2) working days advanced notification so that we may make every effort to accommodate other patients. If proper notice is not received, a fee of $50.00 will be charged to your account for every hour of allotted time cancelled.

Financial Policy

Unless another financial option is pre-arranged, payment in full is due the day of treatment, or on pre-op visits for sedation appointments. Should a patient have dental insurance with assignment to Dr. Fife, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment Options

For your convenience we accept cash, check, and most major credit cards. We also offer short and long-term financing options (interest-free options may apply).

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the treatment discussion appointment.

Finance Charge and Fees

- Balances in excess of 30 days are subject to a finance charge of 1.5% per month (18% annual).
- Returned checks are subject to a $12 accounting fee.

Deposit Policy

Due to the extensive amount of time our staff and providers devote to preparing and reserving uninterrupted time for appointments of two or more hours in length, we require a deposit of half of the treatment fee to make your reservation.

Authorization and Consent

General Consent to Treatment

I agree and consent to a dental examination by Dr. Fife. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Fife to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Fife.

By signing below you attest that you:

- Understand and will comply with office Appointment Policy.
- Understand and will comply with the office Financial Policy.
- Understand and agree to the General Consent to Treatment.
- Authorize the Release of Information.
- Authorize Assignment of Insurance Benefits.

X _____ Date _____

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative Signing this Form: _____

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐Guardian ☐ Power of Attorney ☐ Other (please describe): _____