Appointment and Financial Guidelines for Our Patients

Appointments

Our office cares for patients by appointment only. Appointment time is reserved especially for you. We request that you notify our office at least 48 business hours in advance of a change of appointment. A minimum charge of $75.00 or 15% for changes in appointments without at least 48 hours' notice will be applied.

A minimum of 48 business hours' notice is required for a change in appointment. This time is reserved especially for you and any change in appointment on short notice makes it difficult for our office to offer the time to another patient who would like to see Dr. Fisher. A deposit of 15% may be required at the time appointments are reserved. A change in appointment with less than 48 hours' notice will cause the deposit to be forfeited.

Insurance

The treatment you agree to and receive from Dr. Fisher is based upon his expertise and judgment as a licensed dental professional and is not based on whether you are covered by a dental benefit plan. We estimate payment from your insurance provider using the best technology and methods available to us to verify eligibility and benefits; however no guarantee of payment can be made.

Our business team is happy to file your dental benefits on your behalf and accept the assignment of benefits if allowed by your insurance carrier once eligibility and coverage has been verified. The entire balance for treatment co-pays belongs to you. In the event your insurance carrier does not pay you are responsible for the entire balance.

- We will submit to your insurance 3 times over the course of 3 months. After 3 months, you will be responsible for getting payment from insurance.
- If the insurance company denies paying for your treatment you will be responsible for paying the remaining balance.
- If your insurance company downgrades the fees of your treatment by more than $100.00 dollars you will be responsible for paying the difference.
- If we have not received payment from your insurance company 3 months after date of treatment you will be held responsible to pay remaining balance.

Financial Guidelines

As a condition of treatment in our office, financial responsibilities will be discussed and disclosed to you in writing prior to treatment. Financial arrangements will be made prior to treatment commencing.

Payment is expected at the time of service.

As a courtesy to our patients the following options are available:

- Cash
- Check
- All major credit cards
- Debit cards
- Health Savings Accounts or Flex Accounts
- Care Credit ® - our preferred healthcare financing partner

D.A. Fisher
COSMETIC & GENERAL DENTISTRY

4910 Bissonnet St. Bellaire, TX 77401 (713) 667-8080

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Completed Treatment Guidelines

After delivery of any dental service or dental device you have 30 days to return to our office if you are not satisfied. Delivery of any sort of guard or sleeping device if not satisfied you have 30 days to return to our office for any necessary adjustments. If we need to take additional impressions there will be an additional cost. If you do not return within the 30 days, you will be liable for additional costs associated with additional treatment.

Transfer Records

When requesting to have records transferred we will send all current x-rays and any notes requested. You will be charged 25.00 to have records transferred.

Treatment Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Agreement by Signature

*I understand that any estimate of fees for dental care will be extended for **60** days from the date of the patient examination and discussion of treatment. Fees are subject to change after **60** days.*

In consideration for the professional services rendered to me by Dr. David B. Fisher, I agree to pay the charges for services at the time of treatment, which are Non-Refundable.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read and accept the Appointment and Financial Guidelines presented to me.

Print Patient Name: _____

Signature of Patient, Parent (if a minor), Legal Guardian: _____

Date: _____ Witness: _____

DAVID Fisher
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