SOUTH FAMILY DENTAL CLINIC POLICIES

Cancellation Policy

Due to a high demand in prime appointment times, we require **48 hours** advanced notice should you need to reschedule your appointment. If you cancel or no show, we lose two patients: you and the person who would have been treated in that time slot. I acknowledge that without proper notice, I will be charged **a $100 fee** that is uncollectable by a third party and is my personal responsibility to pay.

X _____
Initials

Direct Billing

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility to know the details involved in your plan**, such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies, please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. South Family Dental can only provide estimates when requested so you may budget your finances accordingly. South Family Dental is pleased to offer you the following payment options. Please check which option you would like to participate in.

☐ **Option A** Payment is due in full the day treatment is rendered. We accept Cash, Visa, Debit, and MasterCard. South Family Dental will process your payment on the date treatment is given. Our treatment coordinator will help you in submitting the necessary documents to your insurance carrier and the insurance cheque will be sent directly to you, the patient.

☐ **Option B** You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion.

If we receive an explanation of covered costs from your insurance company at the time of your visit, you will be required to pay the outstanding balance before you leave.

Please sign below acknowledging that you have read and that you understand the office policies at South Family Dental.

Date: _____ **Signature:** _____

For Option B only:

I, _____, have chosen **Option B**, and hereby authorize any balances outstanding which is not covered by my dental insurance to be **automatically** applied to:

Name (*as it appears on card*): _____

Card Number: _____- _____- _____- _____ Expiry Date: _____

Credit Card **(circle one)** : Visa MasterCard CVV (3 digits on back of card): _____

Signature of Cardholder: _____

Patients this card applies to: _____

Receipts will be emailed to the following address upon request: _____