REUSS DENTAL CORPORATION, INC
WILLIAM M. REUSS IV, DDS, INC
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Welcome !

Thank you for choosing our state–of–the-art office as your dental care provider. We want you to be confident that we are a team of highly trained and skilled staff who will strive to provide you the safest, personalized, and highest quality dental care and service that you deserve to achieve and keep your smile healthy. We aim to give you the best patient experience at each visit while we build a relationship based on the foundation of trust and respect of you as a special individual.
In order to best help you with scheduling and other services we provide, please familiarize yourself with our policies below, then sign and date the bottom as a verification of your understanding and agreement.

I. APPOINTMENT TERMS :

- ***Appointment scheduling*** is a critical part of our day and every appointment time is reserved exclusively for you. With this in mind, please notify us **48 business hours** in advance by **speaking to our staff directly** so we can accommodate other patients who are on the waiting list. Although the office does attempt to make **courtesy** reminder calls, these appointments are your responsibility.
- If there is any change in your personal or dental insurance information and /or health history/medication list, please inform our office as soon as possible prior to your appointment to avoid delays upon your arrival. More importantly, having full awareness of changes to your history of medical conditions, complications , or medications that you have or are currently taking are necessary for us to determine and deliver a safe and effective dental care. We ask that you **arrive 15 minutes early** to register or fill out needed additional forms.
- We realize that unforeseen circumstances befall us all. However, after a second missed appointment made without a 48 hr. notice in advance and a valid reason, you will be placed in a Quick Call List wherein, we will give you a call on the same day when an appointment is made available. You are always welcome to call us as well when you are absolutely sure that you can positively keep a requested time granted our office schedule allows the opportunity.
- After a third missed appointment without a valid reason, a non-refundable prepayment deposit of 50% of the total treatment fees scheduled regardless of dental insurance coverage with a credit card which will be applied toward the service to be rendered, is required before the office will schedule another appointment for you. With repeated missed appointments, we reserve the right to charge you broken appointment fees, namely, **$ 50 for hygiene and $ 100 for doctor's appointments.** With repeated missed appointments deemed as non -compliance, you might be dismissed from our practice.

II. TREATMENT TERMS:

- Your treatment estimate is based on your present diagnosis. **Changes in the body will occur with time, and even with x-rays, some teeth may be in worse condition than originally diagnosed.** We will discuss your options if this occurs. Additional costs may be incurred for which you are responsible.

III. SERVICE CHARGES:

- I understand that a *$25 late charge* will be added to my /or family account for the current month, If I do not pay the entire new balance within **60 days** from the date of service, or if I miss a monthly payment due as agreed upon. If I continue to fail to make payments, a service charge with a periodic rate of 1.5% per month will be added to your overall unpaid balance. _____ **INITIALS**
- In the event of a default which then places my **unpaid balance for collections**, I promise to pay legal interest on indebtedness, collection costs of additional 35% to the outstanding amount resulting from my failure to pay as specified in the financial agreeement, and other related legal fees. _____ **INITIALS**

IV. FINANCIAL AGREEMENT POLICY

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED

A. Modes of Payment and Insurance Policies:

- **All major credit and debit cards, cash, and checks**
- **Third Party Financing** : We offer a NO annual fee, a NO interest , or a low interest NO deposit upon **application approval** through Care Credit or Springstone as long as all fees are ***fully paid*** within the duration of the **chosen *agreed payment plan.***
- **DENTAL Benefit Plan :**
  1. **Estimated Guarantor's Portion** *including deductibles, co-payment , non-covered services, charges exceeding the annual maximum up to the plan's contractual allowance for the procedures* **must** be paid in **full** at the time of service.
  2. **Insurance coverage :** Our office **is not** a party to your insurance policy as this is a contract between you, your employer, and your insurance company such that **estimates** are still subject to final approval by your insurance plan. Therefore, your **final balance due** is subject to change after the Explanation of Benefits had been settled. You are still responsible to know and understand your insurance plan's coverage, exclusions, and limitations.
     Due to the reasons stated, I understand that any statement made by this office concerning my dental benefits cannot be relied upon as a guaranty of coverage. _____**(INITIAL)**

B. Guarantor Responsibilities

- I, _____(PRINT NAME), as the designated **guarantor,** is ultimately responsible for payment of all services rendered on my behalf or dependents **regardless of any insurance involvement.**
  I am also responsible for providing correct updates to my primary and/or secondary insurance coverage prior to a dental appointment, otherwise, payment is due in full at the time of service and any reimbursement will be sent to me directly. If my dental payment claim is denied for any reason (**changes *employment and patient status, reduction of benefit coverage, treatment costs exceeding annual maximum benefits***, etc.), I am still responsible for the total allowable balance due.
  In the event that my dental insurance company downgrades my benefits to a less costly alternative for any procedure, I understand that I am still responsible to pay for the difference between my plan's co-payment and the difference in cost between the plan's approved fees for the services submitted by this office and the alternate service.

FOR PATIENTS 18+ YEARS OLD AND COVERED UNDER A PARENT'S DENTAL PLAN

The undersigned parent(s)/guarantor of (18+ patient name)_____ (name/DOB), agrees to be liable for all charges incurred by the patient, not covered by insurance, even if the services were rendered to the patient after his/her 18th birthday. Unless this office is otherwise notified in writing stating that the 18+ will now assume full financial obligation, you will continue to be held legally responsible for all charges under his/her account prior to to the receipt of this notification.
In the event that an unpaid balance is still outstanding for any reason (pending claim payment or simply unpaid charges) from services performed to the patient prior to receipt of notification by this office, your financial responsibility is still in effect , whereupon, you will continue to receive a statement until all charges incurred by the above mentioned 18+ year old patient are completely settled and paid in full before we take action in separating him off your family account file.

_____**(Initial)**

C. AUTHORIZATION TERMS

- I have read and accept the terms and conditions of the above policies.
- If I have a dental insurance to assist me, I authorize my insurance company to pay Reuss Dental Corporation, Inc. all insurance benefits, otherwise payable to me for services rendered on myself or any family member covered under my plan. I authorize the use of this signature on all insurance submission and authorize the release of all information necessary to secure payment of benefits.

Printed Name of Guarantor _____ Signature _____ Date _____