J. Scott Hadley, DDS 1604 Pheasant Ridge, Sterling (970) 521-7267

Patient Name:_____ Date:_____

# Office Policies

Effective 1/1/16

## Late Cancellations/Missed Appointments

We require at least 24 hours notice if you will be unable to make your appointment so that another patient may be seen in your place. If less than 24 hours notice is given or you fail to come to your appointment, the following fees will apply:

- First time: $25
- Second time: $50
- Third time: ½ the charge of the scheduled procedure (i.e. $508 for a missed crown appointment)

Any fees must be paid prior to being seen again by Dr. Hadley.

## Confirming Appointments

We require **verbal** confirmation of all appointments. We will contact you one to two business days prior to your appointment to confirm. Please provide us with the best two numbers to reach you as well as an alternate number where we can leave a message for you to return our call.

Phone #_____ ☐ home ☐ work ☐ mobile ☐ other_____

Phone #_____ ☐ home ☐ work ☐ mobile ☐ other_____

## Payment

Payment is due at the time services are rendered. If you have dental insurance, we will collect your estimated portion at the time of service. We accept cash, check, Visa, MasterCard and Discover. We also offer third-party financing plans to make treatment more affordable. We do not offer payment plans through the office. A 2% monthly finance charge (24% APR) with a $1 minimum will be added to all unpaid balances. A $20 handling fee will be added for all returned checks, and the checks will be turned over to a third party for collection. The parent/guardian **accompanying** a minor is responsible for full payment. Parental consent must be obtained before definitive treatment is rendered.

## Insurance

Dr Hadley is a Participating Provider (PPO) of Ascent Benefits ONLY and is considered out of network with all other insurances. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Payment of benefits is not guaranteed. Claims must be submitted to determine payable benefits. Any balance not paid by your insurance automatically becomes your responsibility. We only file insurance for local patients. In order to file claims, we need the following information on the date of service:

- Subscriber Name & Address
- Subscriber SSN / ID #
- Subscriber DOB
- Insurance Company Name & Address
- Subscriber Employer Name & Address
- Group #

I acknowledge that I have read and understand the above policies.

_____ _____

Signature of Patient, Parent or Guardian Date