TODD C. KANDL, DMD
GENERAL & COSMETIC DENTISTRY

**Office Policies and Financial Agreement**

It is our desire to provide the highest quality dental care to everyone. The following is a statement of Dr. Kandl's Office & Financial Policies. We ask that you please read, agree to and sign before any treatment is rendered.

**Regarding Insurance**

Our goal is to maximize your insurance benefits. It is important to understand that the insurance contract is between the insurance company and you, the insured. Dental insurance was not designed to pay for all dental care. Treatment recommended by Dr. Kandl is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum.

Please be prepared to show your insurance card and driver's license at the time of your visit. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment the patient/guarantor is responsible for the estimated portion the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. _____ (Initial)

**Payment Options**

Cash, Check, Mastercard, Visa, Discover, American Express or Care Credit

**3rd Party Financing**

With prior approval, we are pleased to offer a choice of No Interest or Extended Payment Plans to qualified applicants. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form. _____(Initial)

**Additional Charges**

A fee of $ 25.00 will be charged on all return checks. _____ (Initial)

**Delinquent Accounts**

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency. Any accounts turned over to collections will be assessed a collection fee of 40%. _____ (Initial

**OVER**

## Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two business days' notice. Our office does not except cancellation or changes in appointments after hours by voicemail. You **must** call during our normal business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____ (Initial)

## Office Hours

Monday 7:30 am – 5:00pm

Tuesday 7:30 am - 3:00pm

Wednesday 7:30 am – 5:00pm

Thursday 7:30 am – 5:00pm

Friday 9:00am – 1:00pm Emergency appointments

I have read, understand and agree to the above Office Policies and Financial Agreements.

_____ _____

Patient/Guarantor signature if patient is a minor Date

_____

Child's Name