Frances H. Yankie, D.D.S.

Thank you for choosing our practice as your dental health care provider. Our practice is dedicated to quality care and exceptional service. We need your assistance and understanding of our appointment, insurance and financial policies. Thank you for your cooperation in this matter.

PLEASE READ AND INITIAL EACH LINE THEN SIGN AND DATE AT THE END

APPOINTMENTS

_____ We respect the importance of your time and we work very hard to schedule appointments the accommodate the scheduling needs of all our patients. In return, we ask that patients make every effort not to change their reserved appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. We require a minimum notice of **48 business hours** for any appointment changes, so we may accommodate another patient. **If less than 48hrs is given, you will be charged a $150.00/ per hour broken appointment fee.** Appointments are confirmed by email, text or phone. If we are unable to reach you, we trust that you will keep your reserved appointment.

INSURANCE

_____ However, we must emphasize that as a dental care provider, our relationship is with you-not your insurance company. It is your responsibility to know your insurance policy and be familiar with your coverage. If you have any questions regarding your coverage or payment of any claim, contact your insurance company immediately. **If payment for service already rendered has not been paid in full in 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from the patient.**

FINANCIAL

_____ **Payments are due at the time treatment is rendered.** That includes all estimated deductibles and co-payments. We accept cash, checks, Visa, Mastercard, and American Express. We also offer Green Sky Patient Solutions. You may contact Green Sky at www.greensky.com or we can help assist you with the application in the office. **If you have a flex/health savings reimbursement program** through your employer, we will be happy to provide you, upon payment in full for your account, with whatever documents are needed for you to obtain direct reimbursement. **Accounts with a balance over 90 days are considered delinquent and may be turned over to a third-party collection service.**

PAST DUE BALANCES

_____ A past due balance is any amount from a prior visit, where insurance is not pending, or an insurance payment has not been received by us within 90 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at the time of service. **Any balance older than 90 days is subject to a billing charge of $10.00 per month or finance charges of 20.0% A.P.**

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services received. I have read the above information and agree to the above stated policy and have received a copy of said policy.

Signature of Patient or Responsible Party _____ Date_____