Schmidt Family Dentistry Inc.

At Schmidt Family Dental Inc. we are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

INSURANCE

We accept most major dental insurance payments, however, we may not be an in network provider for your plan. If we are not an in network provider, review your plan details as reimbursement may vary.

- **No estimate is a guarantee of payment.** I understand that I am responsible for all charges not paid by my insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, I would be responsible for the difference.
- **Workers compensation claims** can be filed for you. Please understand the carrier will assign a dollar amount that will be paid toward the claim, which may or may not cover the entire fee. I understand that any amount not covered by the carrier will be my responsibility.
- **Minors must be accompanied by a parent or legal guardian.** If parents are separated or divorced, I understand that the person accompanying the minor will be responsible for copayment at the time of service.

PAYMENTS

Patient portion and dental lab bills are due at the time services are rendered unless prior financial arrangements have been made.

Payment Options

- All major credit cards are accepted (Visa, MasterCard, Discover)
- Financing option available with CareCredit

Temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

CANCELLATION POLICY

I understand that I need to give 24 hours' notice if I am unable to keep my reserved appointment. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

☐ I understand missed appointments and appointments cancelled with less than 24 hours' notice are subject to a $25 fee.

By signing below, I acknowledge I have read and understand the guidelines above.

Signature of Patient, Parent or Guardian: ______________________________ **Date:** ____/____/____

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