

## OFFICE POLICY

Welcome to our practice. Our office makes every effort to provide our patients with quality dental care by keeping current with the latest post-graduate skill. All of the services rendered are within guidelines of OSHA standards so that our patients can feel comfortable in a healthy, and safe environment

We realize that all of our patients are very busy; therefore, in order for us to keep your appointments on time, we ask that you keep your appointment with us on time. We understand that sometimes cancellations are necessary due to conflicts in schedule, however, we ask our patients to give 24— hour (business hours) notice so that we can accommodate other patients.

**Repeated cancellations without 24 — hour notice will incur a charge.**

Our office offers financial options that are available through our business office. We are sensitive to the fact that not all of our patients are able to make payment in full for their treatment. Therefore, if insurance is involved, please advise our financial office, and they will be happy to submit and accept your insurance as partial payment. **Please be advised that the contract of your insurance is between you and your carrier. Our office is not responsible for any uncovered fees of your insurance carrier.**

**For patients with secondary insurance:** after receiving the explanation of benefits (EOB) claim from your primary insurance, **you** are responsible to send the claim to your secondary insurance company.

Please sign below in agreement that you are ultimately responsible for any unpaid balance to this office.

Signature\_\_\_\_\_ Date\_\_\_\_\_

Please indicate below the form of payment you wish to use to settle your account today.

\_\_\_\_\_ cash or check  
\_\_\_\_\_ Mastercard or Visa

For extensive treatment, please inquire with the business office for payment arrangements.

Once again, we welcome you to our practice, and hope to build a long and lasting relationship with you and your family and friends. Thank you for choosing us as your dental providers.

## RELEASE OF RECORDS

I \_\_\_\_\_, authorize Dr's Finnerty & Wu to release any dental records to my insurance carrier and/or any doctor that may need them.

I understand that my original records stay in this office. In case I leave the practice and need a duplicate copy of records, there will be a \$15 charge.

Signature\_\_\_\_\_ Date\_\_\_\_\_