Bay Smile Docs
Cosmetic, Family and Implant Dentistry
Lynn Haven 271-2341
Fax 271-0679
Panama City Beach 271-0045
Fax 249-2029

BROKEN APPOINTMENT POLICY

The primary goal of Bay Smile Docs is to provide excellent care in a timely manner. In order to reach those goals we have implemented an appointment policy that is both fair and respectful to all of our patients as well as our staff.

Confirmation of appointments is a courtesy to our patients and allows both the patient and staff to address concerns of the patient before the scheduled appointment time. We attempt to confirm all appointments 24 hours in advance during weekdays and on Fridays for Monday appointments. Appointments rescheduled with 24 hours notice will be done at no charge to the patient. We ask that you return confirmation calls in order to hold your appointment time. Appointments cannot be cancelled via text or email.

Failure to return confirmation calls does not constitute a cancellation and patients will be subject to the "No-Show" fee of at least $45 per half hour of appointment time scheduled. Patients that fail to confirm are also subject to having their appointment time given to another patient.

Three broken appointments in one year will result in the patient being dismissed from the practice .

Late arrivals of more than 15 minutes will also result in the "No Show" fee of at least $45.00 per half hour and the patient will be re-appointed. Patients that are chronic late arrivers will be dismissed from the practice.

Bay Smile Docs takes pride in our timeliness and has great respect for our patients' time. We make every effort to be on time and expect that our patients respect the time of our staff and fellow patients alike.

I have read and understand the appointment policy and realize that it is my responsibility to keep my appointments and arrive on time. _____(initials).

I understand that cancellations without 24 hours notice for any reason and late arrivals of more than 15 minutes as well as "No Show" appointments will result in a fee of at least $45.00 per half hour of appointment time.
_____(initials).

I have been given a copy of the broken appointment policy. _____(initials).

I understand that appointments cannot be cancelled via text message or email _____ (initials).

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530 Florida Ave, Lynn Haven Phone: 271-2341 22726 PCP Pkwy. ,Panama City Beach Phone: 271-0045

FINANCIAL POLICY AND PROCEDURE

1. I understand that payment is due at the time that the services are rendered.
2. Bay Smile Docs accepts, Cash, Check, Visa, Mastercard, Discover, American Express and CareCredit cards.
3. Patients who file insurance are expected to pay estimated portions at the time services are rendered.
4. Bay Smile Docs offers a 10% bookkeeping courtesy or discount to those patients who have a treatment plan exceeding $2,000.00 when payment is made in full by cash or check for all services planned regardless of insurance benefits. If patient chooses instead to pay in full by credit or debit card a 5% bookkeeping courtesy will be extended. There will be no discount for patients choosing to use CareCredit due to the costs incurred to the Doctor for enrollment.
5. I understand that dental insurance claims will be submitted as a courtesy to our patients. We will make every effort to make sure your claim is filed accurately and timely. If the patient has not provided the proper information and paperwork no claim can be filed. Patients are responsible to inform our office of any changes to their insurance carrier or policy. We will submit for pre-treatment estimates for major services to determine your insurance benefits upon request. If your insurance company denies your claim we expect payment of the full balance within 10 days of notice from your insurance company. Our professional services are rendered to the patient and not to the insurance company. Treatment is based on patient need and not insurance company benefits. We cannot render services to the patient based on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company. It is the patient's responsibility to be involved with their own insurance company. The patient is responsible for their entire bill regardless of insurance benefits.
6. I understand that Bay Smile Docs is not an insurance provider and therefore I accept the standard fees of the office regardless of what my insurance benefit allows. I understand that there may be a difference between what the insurance company will pay and the cost of services rendered. I take responsibility for the entire fee charged. I will inform Bay Smile Docs if my insurance company has not responded within 60 days.
7. I understand that Bay Smile Docs charges a service fee of 18% annually (1.5% monthly) on all outstanding account balances 60 days or more.
8. I understand that Bay Smile Docs has a handling fee of $35.00 for all returned checks.
9. I agree to pay any attorney, collection or court fees associated with collection of delinquent accounts.
10. I agree to follow the Broken Appointment Policy of Bay Smile Docs which included a fee of at least $45.00 per half hour for appointments cancelled for any reason without 24 hours notice. I understand that this time has been reserved specifically for me. Appointments cannot be cancelled by text or email.

The goal of Bay Smile Docs is to provide you with a first rate dental experience. If we can be of assistance, please feel free to ask. We deeply appreciate your loyalty and encourage you to refer your friends and family.

Bay Smile Docs provides specialty services of a Periodontist and a financial relationship exists. Patient acknowledges that other specialist in this field exists and referrals can be given, to these specialists, upon their request. _____ (initials).

I have read and understand this financial policy and realize that payment is my responsibility. _____ (initials).
I authorize the release of any information and/or x-rays relating to my dental treatment to the insurance company, attorney, or collection agency in collecting the full cost of services rendered to myself and my family. _____ (initials).
I authorize the release of my dental records to offices that I have been referred . _____ (initials).
I have received a copy of the HIPPA privacy policy. _____(initials).
I have received a copy of the Broken Appointment Policy. _____ (initials).

_____	_____	_____
Name (printed)	Signature	Date