Payment Policy

Thank you for choosing us as you Dental care provider. We are committed to your treatment being successful. Please understand that the payment of your bill is your responsibility and is considered part of your treatment. The following is a statement of our Payment Policy which we require you to read and sign prior to beginning your treatment at our office.

1. All payments are due upon completion of you dental appointment. Co-payments and deductibles are estimates, and must be paid when treatment is completed, unless prior arrangements have been made with us. Some services are not completed in one appointment, such as crowns and dentures, in which case your co-pay is due for only the treatment completed that day.
2. For patients having dental insurance, the costs incurred during treatment are the responsibility of the patient. As a courtesy our office will estimate your co-pay. However, any difference between our estimate and what your insurance company actually pays will become the **sole responsibility of the patient**. Your insurance policy is a contract between you and your insurance company; we are not a party to the contract. We can also request a pre-treatment estimate from your insurance company before the treatment is started. Pre-treatment estimates can take approximately 4 to 6 weeks to process and it is still not a guarantee of payment by your insurance company.
3. We accept Visa, MasterCard, Discover, check, debit, and cash.
4. We request that any cancellations be made 48 hours in advance. Although we know personal emergencies and situations arise, if you need to cancel with less than 24hrs notice or do not show up for your appointment more than 3 times in a 12 month period, you may be charged a deposit of $150.00 before scheduling you next appointment.

Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this payment policy.

_____ _____

Patient Signature Date

_____

Staff Signature

COLFAX DENTAL SERVICES

TIMOTHY J. HAGARTY DDS, MS, PC

BRADLEY T. HAGARTY DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I _____ have received a copy of this office's Notice of Privacy Practices

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)