With You for the Long Haul

WOODARD FAMILY DENTAL

OFFICE POLICY AND DECLARATION FORM

Patient Name: _____ Date: _____

Please read the following office policies and sign to acknowledge that you have understood and agreed to them.

1. **Appointment Policy**: Our office requires a minimum of 24 hours' notice for any appointment changes or cancellations. Failure to give proper notice may result in **a missed appointment fee of $50.** If you are more than 15 minutes late to an appointment, without prior notice, this may be considered a missed appointment and the missed appointment fee may be charged.

   We require a positive confirmation for ALL visits. Appointments not confirmed within 24 hours may be forfeited and given to another patient. You can confirm your appointments conveniently on your cell phone. We will call, email and/or send text reminders so please make sure your information is up to date.

2. **Insurance Policy:** We will do our best to estimate your insurance benefits, but the patient is ultimately responsible for any balance not covered by insurance. We will file your insurance claim as a courtesy, but any unpaid balance is the patient's responsibility. We are in-network with Delta Dental Premier members.

3. **Payment Policy:** Payment is due at the time of service. We accept cash, checks, and major credit cards. We also offer financing options through Care Credit, a third-party financing provider. See front desk for details. There is a processing fee for all returned checks or invalid credit card payments.

   We will bill any outstanding balance to the address on file. If you have an unpaid balance to Woodard Family Dental and do not make satisfactory payment arrangements within 60 days of your first bill, your account may be placed with an external collection agency. By signing below, you acknowledge that:

   a. In order for Woodard Family Dental or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Woodard Family Dental and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text

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messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

4. **Medical History:** A complete medical history form is completed at the initial new patient appointment. After that time, please keep us informed of any changes in your medical history, including medication changes and allergies. This information is important for your safety and well-being. You will be asked to fill out the medical history form every 2 years.

5. **Minors:** All children under the age of 18 require a parent or guardian to accompany them to appointments. If this is not possible, our consent to treat a minor must be filled out and a note must accompany the child permitting our office to perform the treatment. The parent or guardian who brings a child for the visit is responsible for payment.

6. **HIPAA Privacy Policy:** Our office complies with all HIPAA privacy regulations to protect your personal and medical information. Please ask our staff for a copy of our privacy policy if you would like more information.

7. **Emergencies**: For all emergencies, call 911. For immediate assistance during office hours, call our office. For immediate assistance after-hours, call 911 or visit your local urgent care.. For non-emergency assistance while the office is closed, please email Dr. Woodard at Doctor@woodarddental.com.

I have read and understood the above office policies and agree to abide by them.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____