OFFICE POLICY

Thank you for choosing Dr. Jaeckle as your dental provider. We would like to welcome you to our practice. We are a family owned practice and our mission is to serve each individual as we would our family and ourselves…to unite and strive together for excellence in dentistry by means of quality care and preventive education.

COLLECTION POLICY

Payment is due at the time of service unless prior financial arrangements have been made. We accept cash, checks and most major credit cards**. Returned checks will be subject to additional fees.** We accept insurance assignment; however, any remaining balance after insurance pays is your responsibility. We will bill you at this time and expect payment in full within fifteen (15) days. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company, at the time we provide service. **ANY ACCOUNT THAT BECOMES 90 DAYS PAST DUE WILL BE SUBJECT TO A $50 COLLECTION FEE AND A FINANCE CHARGE OF 18% OF THE OUTSTANDING BALANCE COMPOUNDED MONTHLY.**

CANCELLATION POLICY & LATE POLICY

If you are unable to keep an appointment, **please give our office a minimum of 24 business hours** notice to avoid a missed appointment fee of **$75.00** per appointment. **If you are late for your appointment, we may not be able to accommodate you.** We will make every attempt to contact you to confirm your appointment. Occasionally we are only able to leave a message or unable to contact you. Please contact our office with any changes in address, phone numbers, or email address**. Due to the high demand for our cleaning appointments, we will attempt to contact you 48 hours prior to your scheduled appointment time. We will require a confirmation of your appointment by 8am the day before** your scheduled appointment; otherwise your time will be released for other patients. You may always leave a message on our recorder to confirm if it is after regular business hours. **We ask that you be responsible for keeping your appointment and notifying us in advance if you can't.**

We thank you for the opportunity to provide your dental health care and welcome any questions you may have concerning your care or our policies.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DR. JAECKLE. I HEREBY ACKNOWLEDGE THAT I AM PRIMARILY RESPONSIBLE FOR MY ACCOUNT AND APPOINTMENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED FOR MYSELF AND MY DEPENDENTS.

_____	_____
Print Patient's Name	Patient/ Guardian Signature
_____	_____
Print Guardian's Name	Date