**Clarke Street Family Dental**

16 Clarke St Suite 15

Lexington MA

02421

In an effort to avoid any misunderstandings, we would like to review our financial and office policies before you begin treatment with our office.

Payment is excepted at the time services are performed. We except Master Card, Visa Discover, and American express.

Although payment is excepted at the time of service occasionally when a balance does remain, payments that are not made in a timely manner are subject to a finance charge.

***For our patient with dental insurance our policy’s is as follows.***

You will need to supply us with the employee information (Name, Date of birth, Social Security number, Employer ID# and employer name) as well as the name and address of the insurance company. We will do our best to answer any questions you may have about your insurance coverage but always suggest that you call or visit your insurance company’s website and review your insurance policy’s handbook.

As a courtesy to our patients, we will gladly submit the insurance claim to your insurance company. We will collect your estimated co-payment and deductible at each visit. We make every effort to determine your insurance benefits when your receive treatment but please consider your co-payment an ***estimate*** until we receive actual payment for your insurance company. Please remember that any information we provide relative to your insurance coverage is based on what is relayed to us by your insurance company via website or telephone conversation.

***Appointment Policy***

We reserve appointment times specifically for each patient so that we may provide the ultimate in service. Please schedule your appointment carefully as there will be a charge to your account for any appointment cancelled without 24 hour notice. Similarly, late arrivals can create a scheduling problems with our patients. Please notify us if you are going to be late. If you have any questions about any of our policies, please feel free to ask any member of our front desk team.

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