COUNTRY HILLS
DENTAL CENTRE

OFFICE POLICIES

APPOINTMENT REMINDERS
Please understand that it is your responsibility to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment. **Please provide us with your email and cell number so we can send you appointment confirmations and reminders**.

CANCELLATIONS
Please provide us with a minimum of **48 hours** notice per appointment should you require to reschedule your appointment. This is valuable time that the Dentist/Hygienist has reserved for you. In the case that insufficient notice is given a $75.00 fee will be charged to you.

DIRECT BILLING INSURANCE & PAYMENT ARRANGEMENTS
The Canadian Personal Privacy Act prohibits us from accessing any information from your insurance carrier. It is your responsibility to know the details involved in your plan (annual maximums, frequencies, other limitations). We extend the courtesy of submitting paperwork to your insurance company, however, to avoid any discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to the maximum.

Below are 2 payment options available to you. **Please choose the best option for you**.

☐ **N 1:** If you require financial assistance, we would be happy to handle all paperwork and deal with your insurance carrier directly. However, you will be required to leave a credit card number on file & your portion will be applied to that credit card once your insurance carrier has paid us its portion. Balances under $100 will be automatically put through to your credit card. For balances over $100 a courtesy call will be made to you before payment is processed. A receipt for payment can be emailed to you. If you would prefer not to leave a credit card number, Option 2 would be your choice.

☐ **N 2:** Payment is due in full at time of service. We accept cash, Debit, Visa, MasterCard & American Express. Your payment will be processed & insurance documents will be generated to submit to your insurance carrier. An insurance cheque will be sent directly to you from your insurance carrier.

I have read, understood and agree to the Office Policy and Privacy Policy.

Patient/Guardian:_____

Signature Date:_____

OPTION 1 ONLY
I hereby authorize any outstanding balances not covered by my insurance carrier to be automatically applied to:
Credit Card (circle one): Visa MasterCard American Express. ***Please give your card information to our Receptionist****