



Office Policy

The intent of these office policies is to ensure effective dental health care for all patients by giving a clear understanding and communication between patient and dental professional.

Appointment Policy

It is recommended that hygiene and treatment appointments are made in advance to guarantee an appointment within the suggested time frame. If you encounter a scheduling conflict as your appointment gets closer, you may reschedule.

We request at least 48 hours cancellation/reschedule notice prior to your scheduled appointment to ensure fairness to all new and existing patients who need to be scheduled. **Please arrive for your appointments on time** to avoid the doctor or hygienist getting behind as we work hard to stay on time for you.

Confirming Appointments

Our office provides patients the option to receive appointment confirmation and reminders via email and/or text messaging. If you would like to be removed from this service, you may do so by going to any of the emails that are sent to you and changing your preferences. Please respond to your appointment reminder messages or call the office to communicate your confirmation.

Insurance

As a service to our patients, we will gladly bill your insurance company with the exception of Medicaid. Prior to doing so we request a copy of your insurance card and driver's license. In the event that your insurance plan or group number changes, it is the responsibility of you the patient or policy holder to provide us with the updated information. In the event that your insurance pays directly to you, please let our office know so that your claim can be completed/closed in our system.

Payment Options: WE ACCEPT: CHECK, CASH, VISA, MASTER CARD, AMEX, CARE CREDIT, LENDING CLUB

~Hygiene and Treatment Under \$300: Payment due in full at time of service unless services are being submitted to insurance. Discount given for payments made in full at time of service: with check (5%), with credit card (2.5%), *excluding Care Credit and Lending Club*. A refund check will be issued to the account holder should insurance pay more than your balance due. **Balance after insurance is due within 30 days of insurance payment.**

~Treatment Over \$300: Due in full at time of service unless services are being submitted to insurance, then, **20% due at time of service**. Discount given for payments made in full at time of service: with check (5%), with credit card (2.5%) *excluding Care Credit and Lending Club*. A refund check will be issued to the account holder should insurance pay more than your balance due. **Balance after insurance is due within 30 days of insurance payment.** *Payment plans may be arranged considering patient circumstances and when patient is in good financial standing with this office.*

Thank you for your attention and compliance to these office policies.
We look forward to working with you in achieving your dental health needs and goals.

By signing below, I acknowledge that I have read, understand and agree to the above office and financial policies of
Kenneth J. Bagby, D.D.S., P.C.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____