Consent For Services

Here at Arlington Dentistry, we strive to put forth the best customer service possible. We try to schedule convenient times for you and your family and set aside time to make sure your appointment goes smoothly and your insurance information is accurate. We want to do everything possible to help control healthcare costs. We ask that all patients pay their portion, in full, at the time of treatment.

Your dental insurance is an agreement between you, your employer, and your insurance company. You insurance company might not pay what they promise to pay - even with a pre-determination of benefits issued by your insurance company. Therefore, estimates given to you by our office, or by your insurance company are *only estimates* based on what your insurance promises to pay. You are responsible for the entire cost of your dental treatment, including all portions not covered by your insurance. Our office bills and accepts payment from your insurance as a courtesy to you. A billing charge and a finance charge of 1.5% will be assessed monthly for account balances over 30 days.

Our office accepts the following payment methods: **Visa, MasterCard, American Express, Discover, Personal Checks, Debit Cards, and Cash**. We will allow our patients to pay in advance if payment plans are needed.

Our office also offers **CareCredit**. CareCredit can provide you with instant financing for the entire balance of your necessary dental treatment. The balance can then be paid in convenient low monthly payments.

Appointment confirmation calls and emails are made prior to each of your visits. A charge of **$50.00** will be made per patient for each confirmed appointment that is not kept or that is cancelled without 48-hour notice. Unconfirmed appointments are not guaranteed. You could be required to pre-pay for your appointment if you consistently reschedule an appointment.

Our office's policy will allow us to put additional effort into patient care. We sincerely appreciate your understanding of this policy we look forward to providing you and your family with the highest quality of dental care.

I have read, and understand Dr. Withrow's office policy.

Name:_____ Date :_____