OFFICE POLICIES

Welcome, and Thank You for choosing Angela Beth Armstead, DDS as your dental health provider. We are committed to your treatment being successful.

Please understand that payment of your services is considered as part of your treatment.

The following is a statement of our financial policy, which we require that you read and sign prior to treatment. THIS IS A FINANCIAL AGREEMENT.

FULL PAYMENT IS DUE AT THE TIME OF THE SERVICE

We accept cash, check, Visa, MasterCard and Discover, CareCredit. We offer an extended payment plan upon prior approval with our office manager on established patients.

REGARDING YOUR DENTAL INSURANCE

Check with your insurance company to verify that we are a network provider. Insurance companies pay less to out of network providers, which means that you will have more of an out of pocket expense. Just because we accept your insurance does not mean that we are a preferred provider in their network. All deductibles, co-pays, co-insurance and non-covered services are to be paid at the time of service. This is based on your insurance policy and benefits. It is up to you to know your policy and benefits. If you do not, then our office manager will estimate your our of pocket expense, but it may not be correct. Each insurance company and policy is different! If there is a remaining balance after insurance payment than a statement will be sent to you for prompt payment in full. If the balance is left unpaid and no payment contract is set up with our office manager then we will forward it to our collection agency.

MINOR AGE PATIENTS

An adult must accompany and sign for treatment at each visit. The accompanying adult is responsible for payment if any balance due, regardless of any court orders.

PLEASE DO NOT LEAVE CHILDREN UNDER 10 UNATTENDED IN THE WAITING AREA.

MISSED APPOINTMENT POLICY

Cancellations must be made at least 24 hours in advance. We reserve the right and do charge for failed appointments.

THANK YOU FOR AGREEING TO OUR POLICIES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

SIGNATURE____ **DATE**_______________

Minor Patient________________________________ **Your Relationship**_______________