

ABOUT OUR OFFICE

We are committed to providing you with the best possible care. Our office staff works as a team to provide dental expertise as well as old-fashioned courtesy and compassion. In order to achieve these goals, we need your assistance, and understanding of our payment and appointment policy.

-WE ACCEPT CASH, CHECKS, OR DEBIT/VISA/DISCOVER/MASTERCARD.

-WE WILL FILE YOUR SERVICES TO YOUR INSURANCE CARRIER, HOWEVER,
YOUR PORTION OF THE BILL IS DUE AT THE TIME THE SERVICES ARE RENDERED.

In addition, many procedures that Dr. Jessup performs may require a deposit prior to making an appointment. In that case, you will be asked to pay a scheduling fee.

MISSED APPOINTMENTS

Unless cancelled, **at least 24 hours in advance**, our policy is to charge for missed appointments at the rate of:

HYGIENE APPT. - \$65.00 DR.JESSUP - \$150.00

I have read the financial policy. I understand and agree to this policy.

X _____
Signature of Patient/Responsible Party

Date _____

IF YOU HAVE DENTAL INSURANCE

We will accept payment from your insurance company commencing with your first visit, if your insurance carrier has a record of paying our office. If you have a policy that pays to the patient only, the patient will be responsible for filing. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid their portion of your claims within sixty (60) days, the balance will be transferred to your responsibility. Please be aware that some, or perhaps all, of the services provided may be considered non-covered services.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients accordingly. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I hereby, authorize P.W. Jessup, Jr., D.D.S., to submit claims on my behalf to

_____ Insurance company.

_____ Date _____
Signature of Patient/Responsible Party