OFFICE POLICY

Payment is due at the time of service.

- Patients who have insurance that will reimburse our office, will pay their estimated portion at the time of service.
- Patients who have insurance that will reimburse them only, will pay for their services in full at the time of service.
- Visa, MasterCard, Discover, American Express, CareCredit, cash and local personal checks with valid ID will be accepted.
- Finance charges of one and a half percent (1-1/2%) per month will be added to accounts which are over 60 days past due.

To insure that the Doctor and Hygienists are able to see scheduled appointments promptly and efficiently, the following scheduling policy will apply to all patients.

- At least 24 hours notice is needed to change an appointment
- Patients who do not provide adequate notice, will not be given another appointment but will be put on a call list.
- Patients who habitually miss appointments take time away from others who are in need of dental services. In fairness to all, these patients will not be re-appointed.
- Courtesy call will be made to confirm your visit. We do ask that you call back to confirm the appointment if we were not able to speak with you personally. If we are not able to confirm the appointment, the appointment will be given to someone else.

X-Rays will be taken routinely at cleaning appointments and on an as needed basis for diagnosis.

- Patients will have bitewing x-rays taken once a year beginning at 5 years of age.
- Patients will have a panorex or full mouth series of x-rays taken at 6 years of age or at the first appointment if one has not been taken in the last 3 to 5 years.

Patients will receive Fluoride treatments beginning at age 3 and continuing until age 18 unless otherwise instructed by a parent.

Patients who refuse any treatment or diagnostic information recommended by the Doctor or Hygienist must sign a release form stating their refusal. The patient is then liable for any complications resulting from the refusal of treatment or diagnostic information.

I have read, understand, and agree to abide by the above
office policy for the office of James A. Gainer, DDS

Signature: ____ Date: __________________