



Jared W. Stubbs, D.D.S.
&
Lisa A. Daft, D.M.D., P.C.

Dear Friends,

This letter is intended to inform you of our usual office policies.

Our office requires payment at time of service. We accept Cash, Checks, Mastercard, Visa, and Discover. We also provide financing through Capitol One and Care Credit. If for any reason, your check is returned you will be responsible for a \$15 returned check charge. Balances over 90 days delinquent are subject to an interest charge at the rate of 1.5% per month (18% annually), and the reasonable cost which the office incurs to collect the balance owed.

For those of our patients who are covered by a dental insurance plan, we will accept payment directly from your primary insurance carrier. You will, however remain responsible at the time of each visit for the charges not usually covered by your provider. Please be advised it is the patient's responsibility to remain aware of your dental coverage, including yearly maximums, co-insurance, deductibles, and any special clauses in your insurance plan. It is also your responsibility to let our office know of any changes with your insurance carrier.

Please understand the patient remains legally responsible for all charges incurred and if the insurance company fails to make payment within 90 days of treatment, you will be required to pay any outstanding balance.

Every effort is made to keep on schedule, so we respectfully ask patients to be prompt and to keep their appointments. If you need to change an appointment we must ask you give us the courtesy of at least one business day notice. If you fail to keep your appointment it is understood that you will be held responsible for a missed appointment fee of approximately \$25 per half hour booked to cover operating costs allotted for your appointment. We try our best to remind patients by telephone prior to the appointment but please do not depend on this courtesy. We mail reminder cards approximately two weeks prior to your scheduled appointment. This card will serve as the confirmation of your appointment. Please call immediately if there is a scheduling conflict.

I hereby acknowledge that I have read, understand, and agree to the policies of this office.

Signature

Date