BOILING SPRINGS DENTISTRY
MARK G. FLETCHER, DMD
AND ASSOCIATES

Insurance and Appointment Agreement

Appointments

_____To allow the best possible care for our patients, we RESERVE A SPECIFIC TIME JUST FOR YOU and make every effort to see you as scheduled. We appreciate your promptness and your consideration in honoring your scheduled time. However, if you need to change your appointment, a 48-HOUR NOTICE IS EXPECTED. If a minimum of 24-hour notice is not given, a failed appointment fee of $50.00 per hour scheduled may be charged.

Treatment Deposits

_____There will be a treatment deposit fee required for treatment that is $200.00 and over. You will be required to pay 10% of your estimated portion the day you make the appointment. If the appointment is broken without timely notice, your deposit will be used towards your cancellation fee.

Payment Options

We accept Visa, Mastercard, Discover, Cash or Personal Check, and CareCredit (6-month interest-free promotion for amounts over $200). We **do not** accept American Express.

Dental Insurance

_____ We will gladly assist you with your dental insurance plan. Most plans cover only A PORTION of the dental fee. As a COURTESY to our patients, we will file your insurance, however, YOU ARE REQUIRED TO PAY THE NON-COVERED BALANCE at the time of service. If your insurance company has not paid within 60 days, you will be billed for the unpaid balance and payment in full will be expected at that time. We recommend that you become directly involved in communication with your insurance carrier to expedite payment.

Patient Agreement

I understand that my insurance policy is an AGREEMENT BETWEEN MYSELF and THE INSURANCE COMPANY. Therefore, I AM ULTIMATELY RESPONSIBLE for ALL FEES INCURRED for my dental treatment REGARDLESS OF PAYMENT OR DENIAL of my insurance claims by my insurance carrier.

I authorize insurance payment directly to Boiling Springs Dentistry.

I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.

If this account is assigned to an attorney or collection agency, I authorize the release of all necessary information and agree to be responsible for all attorney fees and court costs incurred. Patients may be dismissed from the practice for failing to abide by this agreement.

Patient Signature if 18 and older: _____ Date: _____

(Guardian if Minor)