

OFFICE POLICIES
Robert C Williams DDS
Napa Valley Sleep Solutions

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure you begin with a positive experience we have prepared the following information for your review. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

To keep our fees to you as low as possible, we ask that **payment be made at the time of service**. For your convenience you will be provided an estimate for services in advance of your appointment/s to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember, your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. *Please identify which form of payment is most convenient for you at the time of service.*
Cash/Check _____ Visa _____ MasterCard _____ Discover _____ Am Exp _____ Extended Payment _____
Please note a \$25.00 NSF fee will be charged for all returned checks. Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free.

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60-days are subject to a \$10.00 rebilling fee.

CANCELLATIONS

If you are unable to keep an appointment that has been reserved for you **we request you provide us with a 48-hour advance courtesy notice**. To avoid a **broken appointment fee**, early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. We realize that emergencies do occur and we will be flexible under those circumstances.

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

My signature indicates that I understand that policies as outlined and any questions I have with regard to office policies have been answered.

Signature of Responsible Party or Patient

Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

Signature of Staff Member or Doctor

Date