



1184 West Clark Boulevard | Murfreesboro, Tennessee 37129 | 615-895-5212

Office Policy

Thank you for choosing us as your dental care provider. We are committed to providing you the highest quality dental care, utilizing only the best materials and education available. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Registration and History form before seeing the doctor.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. Our office accepts cash, personal checks, Discover, MasterCard/Visa and CareCredit.

Regarding Insurance

For those of you with dental insurance, as a courtesy, we will assist you by processing your insurance claims. You may direct your insurance company to pay benefits directly to our office. However, you co-payment is due when services are provided. *Many services necessary to achieve a high quality, completed result are not always covered.*

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. In the event we do accept insurance payment, we require that you provide a credit card with authorization to bill if your account has not paid in full within 60 days.

Returned checks and balances older than 60 days are subject to collection fees and interest charges.

Minor Patients

The parent, guardian or adult accompanying a minor is responsible for full payment at time of visit. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved form of payment at time of services has been verified.

Missed Appointments

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns. We are committed to providing the most positive experience in dental care.

X _____
Signature of Patient or Responsible Party

Date _____