matt mcgee, DDS, PC

FAMILY & COSMETIC DENTISTRY

office policies

I understand and give my permission to Dr. McGee to perform diagnostic services to help better determine the appropriate treatment needed for my proper dental care. These diagnostic services may include any or all of the following: x-rays; oral examination; biopsy; periodontal evaluation; probing or any other necessary service to help Dr. McGee make an adequate diagnosis.

Once a diagnosis is made, I will be given a treatment plan. The purpose of this plan is to make me aware of the recommended treatment, the estimated cost of the recommended treatment and the anticipated financial responsibility of the recommended treatment. I understand that once the treatment is performed, if my insurance company denies the treatment, or if they pay less than expected, then I am responsible for any remaining balance. Furthermore, I understand and agree that my estimated portion of any and all treatment will be paid upon the day of service. Forms of payment include Visa, MasterCard, American Express, Discover, Check, Care Credit and Cash.

As a courtesy, Dr. McGee's office will file a Pre-Estimate, at my request, for any recommended treatment to help me better determine what I can expect my portion to be. Additionally, as a courtesy, when treatment is performed Dr. McGee's office will file my insurance for payment. However, I understand and agree that if my insurance company fails to pay Dr. McGee within 30 days, or if they pay less than expected, then I become immediately responsible for the balance remaining and will pay such balance upon receipt of statement. If my delinquent account results in collection proceedings, then all additional collection costs, court costs and legal fees will be paid by me.

Dr. McGee's office reserves time, personnel and facilities just for me when I have an appointment scheduled. **I understand and agree that Dr. McGee's office requires a 48- hour notice in advance of my scheduled appointment to avoid a $75.00 cancellation fee per hygiene appointment and a $125.00 cancellation fee per restorative appointment.**

(Please initial)

I grant my permission to Dr. McGee's office to telephone me at home, work or cellular phone to discuss matters related to my treatment, financial obligations or appointments.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent if Patient is a Minor Date