Lefler Dental, P. A.

130 Cordoba Center Drive
Hot Springs Village, AR 71909

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Financial Policy

NOTE: All patients must sign this form.

All Patients

I understand that if I cancel without giving 24 hours notice or do not come to my appointment I may be charged a failed appointment fee of $36.00. I also understand that I may be dismissed from the practice if I miss three appointments without proper notice.

Non-Insured Patients:

I understand that I am responsible for my balance. I also understand that I may be charged a billing charge if my balance goes beyond thirty (30) days.

Insured Patients:

If I have insurance, I understand that my insurance is an agreement between me and my insurance company. If any claim is not settled within ninety (90) days, I understand that I am responsible for the balance. I am also responsible for contacting my insurance company personally if this occurs.

In addition, I understand that I may be charged a billing charge if my balance goes beyond thirty (30) days.

I assign dental benefit payments to be paid directly to Lefler Dental from my insurance company. I hereby authorize Lefler Dental, P.A. to release all information necessary to secure payment of benefits.

_____
Patient's Name

_____ _____
Patient's Signature Date