Clemmons Village Smiles

2265 Lewisville-Clemmons Rd Suite A
Clemmons, NC 27012
(336)766-1366

OFFICE POLICIES

Financial:

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice relies on reimbursement from patients for the costs incurred in their treatment. Payment is expected in full (or the difference between the total and estimated insurance coverage) at the time of your treatment. We will file all dental claims for you on your behalf; however, we cannot guarantee that your insurance will pay a certain amount until they review the claim. If you have dental insurance, we will expect your estimated co-payment (including a deductible, if applicable) at the time of treatment. Patients are responsible for the entire cost of dental treatment, including that which dental insurance doesn't cover. **We offer interest-free payments through Care Credit, which requires pre-approval. Please see our front office associates for more information**
- All emergency dental services and any dental services performed without previous financial arrangements must be paid with cash/debit/credit card at the time services are rendered.
- A service charge of 2.5% per month (30% per annum) on any unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon
- I understand that the estimates for dental care can only be extended for a period of 12 months from the date of consultation

Attendance:

- Appointments are reserved exclusively for your specific dental needs
- Please give 48 hours' notice to cancel or change an appointment
- A $50 fee may be charged for cancellations (or failed appointments, including no-shows) with less than 48 hours' notice
- Please arrange your schedule to accommodate your scheduled dental appointments

Treating Provider:

- Clemmons Village Smiles is owned and operated by Dr. Matt Kostelic & Dr. Raj Patel. We will do our best to schedule appointments with the doctor who planned your treatment, however we can't guarantee that. You may see either doctor depending on which doctor is working on the day of your appointment.

I acknowledge that I have read and understand these office policies.

Printed Name of Patient/Guardian: _____

Signature of Patient/Guardian: _____ **Date:** _____