HARRY RANDEL D.M.D. & Associates
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215.673.0123 610.277.8100

OFFICE POLICY

We would like to take this opportunity to welcome you to our office. Our commitment is to provide you with quality dental care. To achieve these goals, your assistance and understanding of our policy is necessary. Please understand payment of our bill is considered part of your treatment. Therefore we would like you to have a clear understanding of your financial obligations.
Thank you!

CANCELLATIONS:

48 **hours notice** is mandatory when changing appointments. Broken appointments without proper notice will result in a $50.00 charge added to your account.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. Cash, check, MasterCard, Visa, American Express, Discover, and Care Credit are acceptable.

DENTAL INSURANCE:

We are committed to helping you obtain benefits from your coverage. As a courtesy, we verify your coverage and process your dental claims on your behalf. THE DEDUCTIBLE AND ANY CO-PAYMENTS ARE YOUR RESPONSIBILITY.

It is your responsibility to understand the following:
1. Your insurance is a contract between you, your employer, and the insurance company.
   We are not a party to that contract.
2. Our fees fall within the usual and customary range. Services are covered to a maximum allowance determined by each carrier.
3. Not all services are a covered benefit in all contracts. Insurance companies individually select services that will be covered.

SERVICES THAT ARE NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY AND ARE TO BE PAID THE DAY THE SERVICES ARE RENDERED.

As a service to you we will keep you credit card on file: CC #______________________
Visa Master Card Amex Signature_________________ Expiration Date:________
Code:_____

Returned checks and balances older than 30 days will be assessed with finance charges and possible additional collection fess.

I AGREE TO THESE OFFICE POLICIES AND WILL TAKE FULL RESPONSIBILITY FOR THE FINANCIAL OBLIGATIONS ASSOCIATED WITH THE DENTAL TREATMENT I RECEIVE.

_________________________________ ___________
Patient's signature **Date**