Smile
KENNEDY DENTAL

202 East Fifth Street
Marysville, Ohio 43040
www.kennedydentalonline.com
937-642-3434

The mission of Kennedy Dental is to provide quality dental care to each patient while educating them to total wellness and dental health. We provide a service that exceeds your expectations.

FINANCIAL POLICY

It is our commitment to deliver high quality and comprehensive healthcare in a warm, caring environment. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To better assist you with your healthcare investment, below is an outline of our financial policy.

For patients with a dental benefit, please remember that the contract is between you and your insurance carrier, not between the doctor and the insurance carrier. Treatment recommendations are always based on your unique dental needs, not by insurance limitations. Our business team would be happy to provide a complimentary benefits check. For questions regarding specific coverage issues, reference your insurance handbook or contact your insurance company

Our policy is as follows:

- All professional services are the responsibility of the patient. We will file all insurance claims via our electronic software as a courtesy to all of our patients. Your estimated balance for services will be collected the same day service is rendered.
- Payment options are:
    - Cash - includes money orders and personal checks
    - Visa, MasterCard, Discover
    - Care*Credit - a no interest payment plan (subject to credit approval)
- There will be a $30 fee for all returned checks.
- We reserve the right to apply a billing fee for delinquent accounts.

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CHANGE OF APPOINTMENT POLICY

Our goal is to help you commit to all of your dental appointments in order to keep your smile healthy for the rest of your life. Please provide us with 2 business days notice if you are unable to keep your reserved appointment time, so that others needing dental attention can be scheduled.

- We reserve the right to apply a fee for a broken appointment
- As a convenience to you, we will be happy to secure your reserved time with pre-payment
- Please assist us by providing us with the very best means of confirming your appointment

Authorization and Release of Information for Billing:

I authorize my insurance benefits to be paid directly to Kennedy Dental. I authorize the release of any information by Kennedy Dental to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account.

By signing below, you agree to the financial policy of Kennedy Dental, and have fully read, understand and agree to the terms of this contract and have been offered a copy of this agreement.

Signature of Patient or Guardian: _____

Print Name: _____ Date: _____