Jan A Manning DDS

Office Policy Agreement

Welcome to our Office.
We Strive to Offer Friendly Service and Top Quality Dental Care.
The following is an agreement between you and our office to maintain a good Dentist and Patient Relationship, PLEASE READ CAREFULLY.

Payment

ALL TREATMENTS ARE PAYABLE AT THE TIME OF SERVICE.
(Including co-payments, deductibles, and any/all portions not covered by insurance).
If extensive treatment is necessary we offer 4 different *in-office* payment options for balances over $300. Dr. Manning participates with the financial plan *CitiHealthcard* at www.healthcard.citicards.com. If qualified, you may be eligible for an interest free program of up to 6-12 months. More information is available at our front desk.
All payment arrangements are made *prior* to treatment.

Please initial here to indicate you agree to the Payment Policy_____

Appointments

We strive to maintain a reliable schedule with limited waiting time.
We depend on you to be on time for your appointment
and to give reasonable notice of all cancellations.
24 *business hours* notice is required for all cancellations, keeping in mind we are closed Friday.
Failed appointments are subject to charges - Fee level depending on appointment type& length**.**

Please initial here to indicate you agree to the Appointment Policy_____

Dental Insurance on Assignment

As a service to you, we accept assignment of your insurance payment provided all paperwork and necessary information is complete. However, we do require that deductibles, co-payments and any portions not covered by your insurance be paid at the time of service.

Please note: **Not all services are a covered benefit in all contracts. Some insurance policies arbitrarily select certain services that they will not cover and/or have limited fee schedules for certain services that are determined by the policy purchased. We are not a party to your insurance contract and strongly recommend you review your policy=s benefits and monitor your annual allowance. We do not keep track of your available insurance funds/maximums.**

You are responsible for any fee that your insurance company excludes. If no payments have been made by the insurance company by the end of a 45-day grace period the balance will be transferred to your responsibility. You may then work with your insurance company to be reimbursed. All balances are due upon receipt and may be subject to a service fee for accounts over 30-days. We may release your personal information necessary to process your claim and we may dispute your insurance claim on your behalf to obtain coverage for treatment. We want you to receive the full benefit of your dental insurance.

Please initial here to indicate you agree to the Insurance Policy _____

I have read the office policy, and understand it, and agree to its terms.

_____ _____
Signature Date