Office Policies

At this office, we take your health and our role in your health very seriously. We also believe that your optimal dental health requires a partnership between you and your dental care provider. Therefore, we strive to provide the highest quality of dental service to you. Please read and sign the following office policies.

Appointment Policy

Once an appointment is made, please remember this time has been reserved for you. All reminder calls and communications are done as a courtesy and you are responsible for keeping appointments that you have made. A minimum charge will be made for repeated failed or cancelled appointments without prior notification of 24 hours. ***We do not accept cancellations via our voice mail, e-mail, or website system. You must speak with a staff member directly.***

Financial Policy

Our practice is committed to providing the best treatment for our patients and we set our fees based on the quality of treatment we provide. The insurance policy is a contract between you and the insurance company. We do no t provide service passed on insurance coverage, but patient need. You are ultimately responsible for the fees on the account regardless of insurance coverage. Please be aware that by participating in your insurance program, we are providing service at a greatly reduced fee.

Full payment is due and payable at the time of service. We accept cash, check, Visa, MasterCard, American Express, Discover, and CareCredit

Insurance: It is our pleasure to assist you in maximizing your insurance benefits and, as a courtesy, we will file your claims for you. We will estimate your deductible and the portion not covered by your insurance, and this amount is due and payable at the time of service. As it is impossible for us to know the details of every insurance policy, our estimate may differ from the actual coverage, and your account will be adjusted accordingly when your claim is paid.

Out of Network Insurance: Please be aware that all services rendered are charged directly to the patient and that the patient is personally responsible for payment of those fees. We will gladly help prepare the necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of bill.

Any special arrangements must be discussed with and approved by Dr. Thomas Melanson prior to the start of treatment.

Delinquent accounts: Patients with delinquent accounts will be required to make full payment on the account prior to making appointments for additional treatment. A l**ate fee of $30** will be applied to all accounts overdue more than 90 days from the date of service. You are responsible for costs associated with the collection of a delinquent account including reasonable attorney fees and court costs. Dr. Melanson is authorized to disclose portions of the patient's dental record to the extent necessary to determine liability for payment and to obtain reimbursement. Furthermore, you may be dismissed from the practice.

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Office Policies

Furthermore:

You must provide our office with complete and accurate billing information prior to treatment, including current insurance card. If we cannot verify your insurance, you will be asked to make full payment.

You must know and understand the terms of your insurance coverage. If you have questions, please ask us.

You are responsible to Thomas S Melanson DDS LLC for all charges for dental treatment not covered by insurance, including co-payments, deductibles and fees for non-covered services. You are responsible for all fees not paid after 60 days from date of service, regardless of the status of your insurance claim. If claim is subsequently paid, you will be refunded the claim amount.

You authorize Thomas S Melanson DDS LLC to submit claims and you assign insurance benefits to Dr. Melanson including any or all insurance checks that are sent directly to you. Assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as an original.

If you have any questions about our financial policy or have any uncertainty regarding insurance coverage, please do not hesitate to ask.

I have read and understand the above policy and agree to comply with its terms.

Signed (patient or guarantor): _____ date: _____

Print name: _____