

Penney Weeks DMD
Carla Field DDS
228 Ponte Vedra Park Dr. #100
Ponte Vedra Beach, FL 32082

TO ALL PATIENTS

A parent or guardian must be present for a child’s examination by the doctor. Payment is due at the time service is rendered, unless other arrangements have been approved in advance of your visit. We accept cash, checks, MasterCard, Visa, Discover & American Express.

Your appointment is time we reserve just for you. We really count on you being here. If you are unable to keep your appointment, we ask that you give us the courtesy of 48 hours notice. This will allow us to schedule other patients who are waiting for necessary treatment. In the event you fail two or more appointments without a minimum 48hr notice, a \$50.00/hour missed appointment fee will be charged. We appreciate your cooperation.

AGREEMENT REGARDING YOUR INSURANCE COVERAGE

This statement will avoid any misunderstandings commonly found when working with insurance. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. We will be happy to help you process your insurance claim; however, any deductible and/or percentage not covered by your insurance policy is due at the time of service.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

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 are based on the quality of service provided, and generally fall within the “UCR Standards” set by most insurance companies. “UCR Standards” are defined by your insurance company as Usual, Customary and Reasonable fees for this region.
3. Not all services rendered are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental provider of care, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date service is rendered. If you have any questions about the above policies, or any uncertainty regarding your insurance coverage, please don’t hesitate to ask.

FINANCIAL AGREEMENT

I understand the above policies and agree that I am responsible for the payment of all treatment fees on my account. I understand that payment is due at time of service & failure to pay balance due will incur a 50% collection cost of the unpaid debt.

All Patients – Please Sign Below

SIGNED: _____

DATE: _____