WEST ASHLEY
FAMILY DENTISTRY

Thank you for choosing West Ashley Family Dentistry. We look forward to serving you with the best dental care and service possible. If you have any questions regarding payment options, insurance or payment amounts, our patient coordinator is happy to assist you.

Payment Options We request payment on the date of service unless other arrangements have been made. We accept cash, check, and credit cards (VISA, Mastercard, American Express and Discover) as payment. Should you need assistance with your payments we also accept CareCredit, a medical and dental credit card that allows you to pay over time often with no interest. For some procedures payment is required in advance to reserve your appointment time.

Insurance We are happy to file your dental insurance claims for you. **The full fee for your treatment visits will be due on the day of service and your insurance company will be instructed to reimburse you directly for the covered portion of your visit**. If your insurance company contacts our office or you directly and requests more information from our doctors, we will be happy to provide it for you in a timely fashion. In most cases, your insurance company should issue payment to you in approximately two weeks from the date of service.

Missed Appointments We request that you give us 48 hours notice if it is necessary for you to reschedule your reserved time to allow us to offer this appointment to another patient. Last minute cancellations and patients who miss scheduled appointments without notification create costly waste of supplies and patient care time. We do not want these costs to be passed on to our patients, therefore a missed / broken appointment fee equal to the full fee for your reserved time may be charged for those appointments that are missed or canceled with less than 48 hours notice.

Please let us know if you have any questions regarding these policies. Please enter your name below to indicate that you have read our office policies. Your typed name will serve as your signature and acceptance of these policies. Thank you!

Patient/Guardian Name

Date