

OFFICE INSURANCE AND FINANCIAL POLICY OVERVIEW

3911 N. Boulevard – Tampa, FL 33603

OFFICE: 813 209 0338/FAX: 813 209 0388

Tomlinson Dental does not participate in any HMO plans and that I will be responsible for full payment.

❖ Insurance:

1. _____ If you have **HMO** you must verbally inform our front desk prior to treatment. I understand that Tomlinson Dental does not participate in any HMOs and that I will be responsible for full payment.
2. _____ Please realize our office does not know and cannot determine your individual healthcare benefits. We will do our best to maximize coverage for your visit within accepted rules and regulations. However, knowing your benefits and financial liability is ultimately your responsibility.
3. _____ **Not all services are a “covered” benefit in all insurance policies. Your policy is a contract between you and your insurance company, and NOT between Tomlinson Dental and your insurance company. You are responsible for applicable charges as per your insurance agreement (such as deductibles, percentages, co-pays, etc). SERVICES ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE.**

❖ Financial

1. _____ Be aware that payment is expected at the time of service and that our office accepts cash, check ,Visa, Master Card, Discover and American Express. Affordable payment arrangements are available through Care Credit or the Lending Club. **Ask our staff for more information.**
2. **Deposit:** A deposit will be required to hold your reservation for major procedures.
3. **Check Policies:** If a check is returned for insufficient funds and/or closed account, you will be charged a \$35.00 return check fee in addition to your balance owed. You will have 7 business days to make good on your check or other action will be taken.

❖ Appointment Reservation Policy

1. We recognize that reservations made in advance may sometimes need to be rescheduled. A minimum advance notice of 48 hours is required to reschedule your reservation. Reservations can only be rescheduled by speaking to an appointment secretary. Message left on the recorder, are not considered to be proper notification.
 2. **Late Arrivals:** We realize that your time is valuable; therefore patients who are not on the time for their reservation maybe rescheduled.
 3. **Missed or cancellation:** A fee of \$35 is charged for patients that miss or cancel their appt without 48 hour notice.
 4. **Emergency Patients:** Every attempt will be made to see patients on an emergency basis in order to address their needs. Patients may have a wait time as we try to accommodate them into our regular schedule.
 5. **After hours Emergencies:** Current patients of record please call us at: Cell# 813-504-2806.
- _____ **Please inform our office of any insurance, address, email, or telephone changes.**

I have read and understood the above policy and I agree to meet all my obligations

Patient Name

Patient Signature

Date