Office Policies

Appointment Reminders and Cancellations

Please understand that it is your responsibility to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment.

Please provide us with a minimum **48 hours notice** per appointment should you be required to reschedule. If insufficient notice or repeated cancellations occur a **$50.00 fee** will need to be paid prior to rescheduling another appointment. This fee may be applied to your next visit on discretion of Endless Smiles.

Direct Billing Insurance and Payment Arrangements

It is your responsibility to know the details of your insurance plan (annual maximums, frequencies, and other limitations). If you know your plan we can help you make choices for best treatment options and optimal health of your mouth. We extend the courtesy of submitting paperwork to your insurance company however you need to be aware of the payment options available to you. Please circle which option you would like to participate in and fill out information as necessary.

Option 1 Payment is due **in full** at time of service. We accept cash, cheque, or credit card. Your payment will be processed and insurance document will be filled out for you to submit to your insurance carrier. Payment will be sent directly to you from your insurance company.

Option 2 If you require we would be happy to handle all paperwork and deal with your insurance carrier directly. However, you will be required to leave a credit card number on file and your portion will need to be paid at time of service. Once your insurance carrier has paid us its portion any balance left will be applied to the credit card on file. All credit card information will be kept confidential in your patient record. A copy of the credit card receipt along with a detailed explanation will be sent to you.

Please provide your insurance information below:

	First Insurance Plan	Second Insurance Plan
Insurance Company:		
Name of employer insurance plan is with:		
Name of insurance plan owner:		
Date of birth of the insurance plan owner:		
Group plan #:		
Individual plan #:		
What is the insurance plan benefit year (Jan-Dec, 12 month period)?		

Please have insurance cards with you so that we may take a copy for our records.

Please provide your credit card information below if choosing option 2:

Visa or Mastercard	
Credit card #	
Expiry date:	
Name on credit card:	
Signature of cardholder:	
Today's date:	

All information will be kept confidential.

I, _____ authorize Endless Smiles Inc. to apply any outstanding balance on my account not covered by my insurance plan to the credit card listed above. I understand Endless Smiles will send a copy of the credit card receipt to my current address on file.

I have read and agree to the office policy. I understand that I am fully responsible for the fees of the services rendered, regardless of any insurance I may have.

Signature _____

Date_____