

*The team at Serene Oaks Dental strives to provide excellence
in personalized patient care by exceeding expectations
and building quality relationships in a
welcoming and relaxing environment.*



We value a comfortable and stable bite, as well as an attractive smile for each of our patients. Therefore we have committed to seek the highest quality of continuing education. This allows us to partner with our patients to provide the best treatment options and perform exceptional dentistry. Serene Oaks Dental believes in clear and honest communication enabling us to work together to support one another and our patients to achieve oral stability and personal well being.

Office Policies:

~ As a courtesy to our patients with dental insurance, we gladly submit dental claims to your insurance company for payment. Our advanced systems are able to **ESTIMATE** patients' portion of payment from services rendered.

- It is agreed that my insurance is to be billed for all services provided by Serene Oaks Dental (S.O.D.) as long as my insurance is in effect and the insurance limits have not been exceeded.
- I consent to the release of my dental records by S.O.D. to my insurance company if necessary for my bills to be paid.
- By the request of the patient, S.O.D. can file a Pre-treatment Estimate of Benefits to the insurance company for a \$25.00 fee. I understand and agree that I will be charged \$25.00 for **each** Estimate that I request. I also understand that a Pre-treatment Estimate of Benefits **does not guarantee payment.** Benefits will be determined when services are completed
- I understand that the information my insurance company provides to me or S.O.D. is **NOT A GUARANTEE** of the benefits provided or paid by my insurance company. I understand that I am responsible to know my insurance benefits. Therefore, I accept full responsibility for all charges for services provided by Serene Oaks Dental. I understand that I am responsible to pay for all balances that dental insurance does not cover.

~ I agree to pay the **entire** estimated patient balance at the time my dental services are rendered.

~ I understand that S.O.D. will charge interest on unpaid balances 60 days after the date of service and I accept responsibility to pay these interest charges.

~ I understand that in the event that S.O.D. has been unable to collect payment for services that S.O.D. has the right and will turn my account over to a collection agency.

~ I understand that there is a \$25 charge for NSF checks that are returned to S.O.D.

Commitment to Appointments: We will reserve time for you. We will give you our utmost attention and care and will rarely keep you waiting. An appointment scheduled in our office is a bond of trust that our team will be here to serve you and that you will be on time and prepared for your appointment.

We maintain an efficient schedule because we understand that our patients' time is important. I understand that I may be charged a cancellation fee for any appointment that does not adhere to the **Cancellation/Changed Appointment Policies** below:

- Cancellations or changes of appointments must be made at least 48 hours in advance.
- I may be required to provide a credit card number to hold longer appointment times.
- Failure to cancel an appointment with 48 hour notice or failure to come to a scheduled appointment may **RESULT IN A FEE of \$75-\$100 per hour** which **cannot** be billed to your insurance company.

By signing this form, I consent that I have reviewed and agree with the above policies of SERENE OAKS DENTAL.

Patient Signature

(if minor) Signature of Parent/Guardian

Serene Oaks Dental Representative

Date