Beattie Family Dental, P.C.
1544 W Kimberly Rd
DAVENPORT, IOWA 52806
(563) 386-6910

## Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care. Please understand that payment of your dental bill is considered part of your treatment and due at the time services are rendered. For your convenience we accept Cash, Check, Visa, MasterCard, Discover, American Express, and Care Credit.

For our patients that have insurance we will, as a courtesy to you, file your dental claims. Please understand that we will provide an insurance **estimate** to you, however, it is not a guarantee that your insurance will pay exactly as **estimated**. While we do our best to understand your dental plan, there are times when an insurance company will pay less than anticipated. If the insurance company pays less then estimated, you will receive a bill. In the event they pay more then estimated you may request a refund or leave the credit on your account towards future dental treatment.

***Please note:*** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service, you will be responsible for any collection charges incurred up to 35%.

## Appointment Policy

In the event that you cannot make a scheduled appointment, please give us at least 24-48 hours notice prior to the time of your appointment, and we will be glad to reschedule you.

A failed appointment occurs when an appointment is missed without proper notice. In the event of a failed appointment, a failed appointment fee may be charged.

Two failed appointments within a one year period will result in patient dismissal.

**Consent:**
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I understand that responsibility for payment for dental services for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, or collection charge will be added to any overdue balance.

**Patient Signature (Parent of Child)** ______________________________ **Date** _______