South Tampa Dentistry — Office & Payment Policy

3308 S. Dale Mabry Hwy.
Tampa, FL 33629
P: 813.835.0090
F: 813.835.0638

PATIENT'S
NAME (PRINT) _____
First M.I. Last

Welcome to South Tampa Dentistry. The following is an outline of our Office and Payment Policy. Please read it carefully:

- Please notify our office when you have a change of address and/or phone number.

APPOINTMENT CANCELLATIONS

- When time permits, as a courtesy, we will call to confirm your appointment. However, it is the responsibility of the patient to **keep or cancel** the appointment whether or not we were able to make contact for confirmation.
- **24 HOUR NOTICE** IS REQUIRED WHEN CANCELLING AN APPOINTMENT. FAILURE TO CANCEL IN TIME WILL RESULT IN A $25 FEE PER 45 MINUTE APPOINTMENT.
- We will be unable to reschedule an appointment if you have three (3) or more broken appointments.

INSURANCE

- We will gladly file your insurance as a courtesy and accept assignment of benefits. However, if the insurance company does not pay after 60 days, it will be **your responsibility** to pay South Tampa Dentistry for the services and resubmit for the insurance on your own.
- You are responsible for payment of any services applied to your deductible.
- You are responsible for payment of any amount over your annual maximum allowance which includes dental services performed in this office, as well as any other offices.

PAYMENT POLICY

- Total payment is due for services when treatment is rendered. We accept Visa, MasterCard, and Discover.
- There will be a 1.5% service charge on any outstanding balances.
- Should legal action be instituted to enforce the payment for services rendered, the signer(s) agrees to pay court costs and/or reasonable attorney fees incurred by the holder in such action.

Please inquire with our staff if you are uncertain about the subjects outlined above. Your signature will certify that you understand and will comply with this policy.

There will be a $25.00 service charge on all returned checks.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICY.
PATIENT'S
SIGNATURE: _____
(or Legal Guardian if minor) SIGNATURE DATE

South Tampa Dentistry

SIGNATURE ON FILE

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PATIENT'S NAME (PRINT):

FIRST	M.I.	LAST

I hereby authorize payment directly to South Tampa Dentistry of the dental benefits otherwise payable to me.

SIGNATURE OF INSURED PERSON :

SIGNATURE	DATE

South Tampa Dentistry is authorized to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for my term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

I know I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:

SIGNATURE	DATE