AFRESH
DENTAL HEALTH

Insured and Uninsured Payment Policy

Welcome to Afresh Dental Health, LLC. It is our intention to make your visit as comfortable as possible. Please take the time to look over our office payment policy. If you have any questions, please do not hesitate to ask any team member.

Please provide us with your dental insurance card. We will gladly process your claim, but we do request that you pay your estimated portion (deductible and/or copay) the day of treatment. Signing below authorizes Afresh Dental Health to bill your insurance carrier and apply the insurance payment to your outstanding account balance.

If you do not have dental insurance, payment in full is due the day of treatment. We also accept check, cash, or Visa/MasterCard/Discover.

Any amount not covered or paid by your insurance carrier after 30 days is your responsibility.

Our office requires a minimum of 24-hour notice to cancel or reschedule appointments.

- After the **first** missed appointment, the patient or guardian will be notified by letter of our office policy. The appointment may be rescheduled.
- If a **second** scheduled appointment is missed, a $52 fee will be charged. The appointment may be rescheduled.
- If a **third** scheduled appointment is missed, it will be necessary to terminate our professional relationship with the patient and family.

In signing below, I agree to assume full responsibility for payment of any treatment provided.

Patient Name: _____ DOB: _____

Responsible party: _____ Relation to Patient: _____
(Please print name)

Signature: _____ Date:_____

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