



## Insured and Uninsured Payment Policy

At Afresh Dental Health, we truly value your time and are excited to care for your smile! To keep our schedule running smoothly and make sure each patient gets the time they deserve, we've created a simple payment and reservation policy.

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.

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

If you do not have dental insurance, payment in full is due the day of treatment. We also accept Credit/Debit cards, HSA/FSA cards, check, or cash

We understand that life happens and schedules can change. However, when appointments are missed or canceled without enough notice, it affects our ability to serve all of our patients efficiently.

To help us provide the best care for everyone, we have the following policy:

- **First missed or same-day canceled appointment:** We'll make a note in your account and offer a courtesy reschedule.
- **Second missed appointment or frequent short-notice cancellations:** A **reservation fee** will be required to hold your next appointment. This fee will be applied toward your treatment cost at the time of your visit.
- **Third missed or same-day canceled appointment:** It will be necessary to terminate our professional relationship with the patient and family.
- **Late cancellations:** Please provide at least **48 hours' notice** if you need to change or cancel your appointment to avoid fees.

This policy helps ensure that we can reserve time for patients who truly need care and respect everyone's time—including yours!

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

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_