Barksdale and Hastings DDS
2606A Bens Branch Drive
Kingwood, TX 77339

Office and Financial Policies

Welcome, and thank you for choosing Barksdale and Hastings, DDS for your dental care. We are committed to providing you with the highest quality dental care in an efficient and cost-effective manner. We hope that by providing you with our policies in advance, we can prevent a misunderstanding or frustration at the time of your visit.

Initials:______ **Insurance:** The patient is responsible for knowing their insurance benefits including their deductible and out-of-pocket expense. If your insurance company does not accept assignment of benefits and the payment is mailed to the policy holder, our office **must** collect on the date services are rendered. Deductibles and patient's financial portion including any balance will be collected at the time of service. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for timely payment on your account.

Initials:______ **Cancellations:** Your dental appointments are scheduled exclusively for you**.** We call and confirm all of our appointments the day before. If you are unable to keep your appointment, please call our office 24 hours in advance to cancel/reschedule your appointment. If you do not cancel within 24 hours, you may be charged a broken appointment fee of $50.

Initials:______ **Patient Balances:** Please be prepared to pay the current visit charges as well as any past balances on your account. Deductible and out-of-pocket expense and non-covered services will be requires at time of service. For your convenience, we take cash, checks, credit cards and Care Credit.

Initials:______ **Late Arrivals:** We only schedule one patient each appointment time, and we do our best to stay on time. So when a patient arrives late, it is impossible to do so. If you arrive 15 minutes late you may be asked to reschedule your appointment to keep our schedule on time.

Initials:______ **NSF checks:** A $30 return check fee will be assessed on all NSF checks. If you have 2 NSF checks on file, check payment will no longer be a payment option for you. But we will gladly accept cash, credit cards and Care Credit on your future visits.

Initails:______**Collections:** You will receive monthly statements from our office for balances owed. After 90 days, a finance charge of 1.5% per month will be assessed on any unpaid balance. Please make payment arrangements, if necessary, in order to keep your account in good standing. Non-payment will cause your account to be turned over to collections. You **may not** be seen in our office until the account is paid in full.

I have read, understand and agree to the above Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing.

Print Patient name:____

Patient or Responsible Party Signature:____ Date__________