

**Amy F. Temple, D.D.S.**  
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We are pleased to welcome you to our practice. Thank you for choosing our office. Please read the following information.

**Payment and Insurance Claim Processing Policy**

Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor. Please note that we are not a **network provider**. (We do not accept Medicaid or NC Health Choice). We will be happy to file your insurance; however, we ask that you please furnish the correct insurance information and a copy of your dental insurance identification card. We do NOT file secondary insurance. *In the event the insurance company does not pay in a timely manner, you are responsible for the entire balance.*

**Patient's Responsibility**

- You are **responsible** for *any* deductible and *estimated* portion at the time services are rendered.
- You are **responsible** for *all* charges not covered by your insurance company.
- You are **responsible** for *full* payment the day of service if there is no insurance on file.
- You are **responsible** to send payment for dependents not accompanied by an adult.

**Important**

- **Emergency Visits:** If you are not a registered patient of record, **payment in full** is required at the time services are rendered. Any dental insurance will be filed as a courtesy for your reimbursement.
- **Missed Appointments:** Missed appointments or cancelled appointments of less than 24 hours notice may be **charged a fee ranging from \$25-\$75** depending on the length of the original appointment. After two missed appointments, you will not be rescheduled.
- **Delinquent Accounts:** Finance charges will be applied at the rate of 18% annually on all balances over 90 days. We utilize the services of a collection agency when accounts become 90 days past due. Additional charges may be accrued by the agency and you will be responsible for these collection fees. You will be **DISMISSED** from the practice for a delinquent account.
- The parent or guardian *who brings* the child for their visit is responsible for the payment independent of what any divorce decree may state. Reimbursement must be made between the divorced parties. **We will not intervene.**



I, the undersigned, have completed the patient information and health history form, **read and understand** the above payment policy, and **agree to it**. I certify that I am the patient, or duly authorized general agent of the patient, authorized to provide the information requested. I understand that even though I may have dental insurance coverage, I am responsible for all payments of services rendered.

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