Amy F. Temple, D.D.S.
840 Broad St.
Kernersville, NC 27284
Phone: (336) 993-5599
Fax: (336) 993-0877

Welcome to the office of Dr. Amy F. Temple. Thank you for choosing our office. Please read the following information.

Payment Policy:

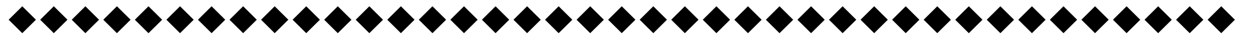
- **Emergency Visits:** If you are not a registered patient of record, payment in full is required at the time services are rendered. If you have dental insurance, payment is still required in full; however, we will file the total amount as a courtesy and request that you be reimbursed.

- **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.

- **Patients with Dental Insurance:** **THE BILL IS YOUR RESPONSIBLITIY.** We will be happy to file your primary insurance. We ask that you please provide the correct insurance information and a copy of your dental insurance identification card. We will *estimate* the percentage your insurance will cover and the portion you will be required to pay at the time services are rendered. We will accept payment from the insurance carrier. 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*. Be aware that most insurance policies have a yearly deductible, which must be met on the first restorative visit.

- **Patients with No Dental Insurance:** Payment is expected on the day services are rendered.

- **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.



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:**_____________________