Anderson&Hoffner
DENTAL CENTER
We smile when you smile.

BILL ANDERSON DDS, AUSTIN HOFFNER DDS
1401 East Sandusky St. Findlay, Oh 45840 419-424-5850

ANDERSON&HOFFNER DENTAL CENTER WELCOMES YOU!!!

Thank you for choosing our office! We strive to deliver high quality dental care to our patients with a professional level of customer service.

Our goal is to provide the service and care that you deserve. At the onset of your treatment we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices. Please understand that we can only provide you with an estimate. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review our office policies.

Appointments & Deposits:

- I understand that at Anderson & Hoffner Dental Center the appointment is considered the Confirmation. Although I may receive reminders, by setting the appointment I am making a A commitment to a portion of time reserved specifically for me.
- As a courtesy, I will notify Anderson & Hoffner Dental Center if I cannot make an appointment at Least 48 hours prior to the scheduled time.
- For patients with a history of missing or cancelling appointments at the last minute, Anderson & Hoffner Dental Center reserves the right to double-book future appointments and may require a Non-refundable deposit in order to re-schedule.

AS A COURTESY TO STAFF AND PATIENTS PLEASE PROVIDE 48 HOURS NOTICE IF YOU ARE UNABLE TO KEEP AN APPOINTMENT. PLEASE CALL DURING BUSINESS HOURS.

Dental Insurance:

- As a courtesy we are happy to bill your dental plan for services. But do keep in mind that you're Dental benefits are a matter of contract between you and the insurance company not Anderson & Hoffner Dental Center. The insurance carriers base the amount of benefits on a fee schedule that they arbitrarily develop. For this reason, you may receive less of a benefit than we estimate for you, there is no guarantee of payment.
- Regardless of coverage your estimated portion is due in full the day of treatment. If Your dental plan does not pay with-in 60 days you must pay any outstanding balance and seek Reimbursement from your dental plan.

REMEMBER THAT DENTAL INSURANCE IS NOT DESIGNED TO COVER ALL OF YOUR DENTAL NEEDS, THE AMOUNT IS BASED ON THE PLAN SELECTED AND PURCHASED BY YOUR EMPLOYER.

Financial Agreement:

- Forms of payment accepted at Anderson & Hoffner Dental Center:
  Cash, Check, Credit cards (Visa, MasterCard, and Discover)
  Care Credit (Third party financing payment plan)

- I understand that all co-pays and patient portions must be paid at the time of service
- If I choose to discontinue care before treatment is complete, I may receive a refund less The cost of care received and any other non-refundable parts, supplies or lab fees.
- I acknowledge and agree that all accounts past 60 days shall bear a compounding interest rate Of 1.5% per month. In the event that I do not pay for performed services Anderson & Hoffner Dental Center may place my account with a collection agency. I further agree to pay reasonable collection Fees, attorney fees and court costs incurred with the collection of an overdue account.

CHILDREN OF DIVORCED/SEPERATED PARENTS

- Unless you give us a signed, notarized court order to keep on file, both parents are financially responsible for your child's treatment. Anyone else who might bring your child in for a visit also assumes this responsibility. Please keep in touch with the office whenever financial responsibility changes for your child. We will work with you as much as possible.

Responsible Party:

- As the responsible party, I understand my financial responsibilities to Anderson & Hoffner Dental Center for myself, spouse and/or children's accounts.
- I hereby authorize and direct all my insurance carrier(s) to issue payment directly to Anderson & Hoffner Dental Center.

____________________________________ __________________
Signature of Responsible Party/cardholder Date

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Print name of responsible Party/cardholder

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Anderson & Hoffner Dental Center's **Notice of Privacy Practices**

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Patient name (please print)	Patient, Parent or guardian Signature	Date