

Dental Wellness of Lexington  
527 Wellington Way, Suite 120  
Lexington, KY 40503

**Policies**

The team at Corporate Center Dental Care pledges to deliver you quality, courteous care in a clean and comfortable atmosphere. Our team will offer efficient and experienced service, always listening to you and being respectful of the time you spend with us. We promise that we will always provide you with exceptional dental care. We are your home for professional dental excellence.

**Appointments**

It is necessary that we work by appointments. Unfortunately, emergencies do occur that occasionally causes delays in our schedule. However, we will try our best to honor your appointment time. Please, in turn, remember that the time we have reserved for you is exclusively for you. Any changes in your schedule will affect our schedule as well. We do require **2 business days** notice for any appointment changes. We reserve the right to charge the credit card we have on file for your account, in the event that 2 or more appointments are cancelled/rescheduled without the proper 2 business days' notice.

**Financial**

In the interest of better understanding, we believe financial arrangements must be completely understood and agreed upon before treatment has begun. Your treatment will be explained to you and you will be given an estimate of the fees.

Your dental treatment fees can be handles in one of the following ways: You may pay cash, check, or credit card (Visa, MasterCard, American Express and Discover). **We do expect payment for services as they are rendered.** If you feel you will not be able to pay the balance due by you as each service is rendered, you will need to discuss the advantages of using Care Credit, Springstone Financing or Chase Health Finance, which will afford you small minimum monthly payments. Please feel free to discuss any of the above payment options with our Financial Coordinator. Insurance deductibles, co-pays, and fees or portions of fees not covered by dental insurance are also due at the time of service and are payable in the same fashion as stated above.

**Dental Benefits**

Congratulations on having dental insurance! As a convenience for you, our office will submit charges for services to your insurance carrier, **but we consider the patient responsible for the account.** In other words, the services provided by any dentist amounts to an agreement between the patient and this office. The insurance relationship constitutes an agreement between the carrier and the patient.

It will be helpful to us for you to bring any information regarding your insurance plan with you to keep in your patient record for reference. This will enable our business office team to better assist you in **estimating** the percentages payable by your particular plan. If you forget to bring your insurance information, please send us a copy within the next two days of your appointment. (If you don not bring your insurance information with you, will be expected to pay for the services at the time they are rendered.) If there is a question about your account about your insurance, please call. Many times a phone call will prevent any misunderstanding.

**If your insurance company has not paid within 45 days of the date the form was filed, the full amount of the claim will be your responsibility.** It will then be your responsibility to contact your insurance carrier concerning the outstanding claims. We will be happy to receive your calls concerning questions about your insurance, and we can tell you which claims have been received, for what amount, which claims are outstanding, and when the claims were sent. You should then take any questions to the insurance carrier.

Should you have any questions about our practice policies, please feel free to discuss them with our business office team. We thank you for the confidence you have placed in us. We are complemented that you have chosen us. You may rest assured that we will do everything in our power to make your visits to our office as pleasant as possible.

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Patient Signature (Parent's Signature if patient is a minor)

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Date