Our Policies

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WELCOME to Lincoln Dental. It is our pleasure to have you as our patient. Our commitment is to provide you with the best possible dental care and to keep you informed of treatment recommendations and financial obligations.

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

The following is our office payment policy:

* Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges of **1½%** per month (**18%** per anum) and any other expenses incurred in collecting your account.
* As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided. However, we do not guarantee any estimate, and should your dental plan pay less that expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans.
* Please remember that the staff sets aside a designated amount of time for your particular type of treatment. If you miss an appointment without giving a 24 hour notice, you may be charged a $50 fee to be paid prior to scheduling your next appointment. We appreciate your understanding of how important keeping appointments is to the doctor and our other patients.

Consent:

* I authorize the staff of Lincoln dental to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
* I assign all insurance benefits to Lincoln Dental.
* I understand the above information and guarantee all forms were completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information provided.

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Signature of Patient, Parent or Guardian Date