CHINOOK FAMILY DENTAL CARE

Cancellation Policy

We require **48 hours** advanced notice should you need to reschedule your appointment. If you short notice cancel (excluding sickness and family emergencies) or fail to show for a confirmed appointment, a $100 fee may be charged.

X____________ Initials

Direct Billing

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility to know the details involved in your plan**, such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies, please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. Chinook Family Dental Care can only provide estimates when requested so you may budget your finances accordingly. We are pleased to offer you the following payment options. Please check which option you would like to participate in.

☐ **Option A** Payment is due in full the day treatment is rendered. We accept Cash, Visa, Debit, and MasterCard. Chinook Family Dental Care will process your payment on the date treatment is given. We will help you in submitting the necessary documents to your insurance carrier and the insurance cheque will be sent directly to you, the patient.

☐ **Option B** You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion. We will ask for your authorization for any amount over $100.

If we receive an explanation of covered costs from your insurance company at the time of your visit, you will be required to pay the outstanding balance before you leave.

Please sign below acknowledging that you have read and that you understand the office policies at Chinook Family Dental Care.

Date: ____________________________ **Signature:** ____

For Option B only:

I, ____, have chosen **Option B**, and hereby authorize any balances outstanding which is not covered by my dental insurance to be **automatically** applied to:

Name (*as it appears on card*): ____

Card Number: _____________- ______________- ______________- _______________ Expiry Date: ____________

Credit Card **(circle one)** : Visa MasterCard CVV (3 digits on back of card): _____________

Signature of Cardholder: ____