

Kemper Meadow Family Dentistry
John P. Harmeyer, D. D. S.

WELCOME TO OUR OFFICE

It is our goal to provide you and your family with the best possible dental health care. We practice preventative dentistry and stress the importance of regular visits to achieve and maintain excellent oral health.

We strive to operate on a prompt and timely schedule. As emergencies arise, we make every effort to accommodate such cases the same day, which will occasionally cause delays for previously scheduled patients. If for any reason we are unable to maintain a scheduled appointment, you will be notified and give the option of rescheduling. We ask in return that you please give us and our other patient the courtesy of 24 hours' notice for and cancellations or late arrivals. There is a minimum \$35.00 charged for late cancellations and missed appointments.

FINANCIAL AGREEMENT

Our office will gladly process your dental insurance claim and approximate the company's payment. Estimated patient deductibles and/or co-payments are expected at the time of service.

Although we honor dental insurance, the account balance is ultimately the responsibility of the account holder. For non-insurance patients, all charges incurred are payable at the time of service. Credit balances of \$15.00 or less will not be refunded unless requested.

We honor Visa, MasterCard, and Discover bank cards.

INFORMED CONSENT

We make every effort to clearly and precisely explain all treatment and financial situations in order for you to make an informed decision about consenting to treatment. All information gathered by our staff, clinical and administrative, is strictly confidential. Your records will only be released to carry out treatment, billing, specialist referrals, or for patient relocations. Your signature on this form serves as consent for release of personal information in such circumstances, and as an Acknowledgement of Receipt of Notice of Privacy Practices. Our full privacy notice is available and posted in the office.

I have fully read and agree to the contents of this notice.

Patient Signature

Date