SETH ROTH D.M.D.
450 PEARL STREET
STOUGHTON, MA 02072
781-344-5543

OFFICE POLICIES

Scheduling--We will make every effort to schedule an appointment at the most convenient day and time for you. Our office prides itself on seeing our patients at their scheduled time and asks that our patients extend us the same courtesy. Any patient who arrives fifteen (15) minutes late for an appointment will be asked to reschedule their appointment and will be assessed a missed appointment fee of $25.00 Please initial_____.

Cancellation-No show--We require twenty four (24) hours advance notice prior to your schedule appointment time for any changes or cancellations. This allows us the time we had previously reserved for you to be appointed to another patient. We do understand illness and emergencies do occur and we will accommodate for those rare occasions. A fee of $30.00 will be charged to your account for not honoring this policy. Any patient who habitually breaks this policy will be dismissed from our practice. Please initial_____.

Non Insured--We are happy to provide services to our patients not participating in a dental insurance program, but we must insist payment be made on the date services are rendered.

Insured—At Dr. Roth's office, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. For our patients with dental insurance benefits, here are some important factors you should know.

Your dental benefits are a contract between **your employer and an insurance company.** If you have any questions regarding your dental benefits please contact your insurance company or employer directly.

Upon arrival our staff will obtain a copy of your current insurance card. We will call your insurance company to verify benefits. ***Insurance companies give us a disclaimer when we call therefore, we do not guarantee that when we obtain benefits that they will be correct*** It is in your best interest to also verify and understand your insurance plan. We recommend paying close attention to **time limitations, deductibles, maximums, missing tooth clauses, waiting periods, and non-covered services.**

Our office will gladly bill your insurance company as a courtesy to our patients. Therefore, we collect deductibles and **"estimated"** co-payments at the time services are rendered. This is not a guarantee that this will be all that you owe. We do our best to estimate as close as possible but we make no guarantee regarding monies owed once a claim has been paid.

Our office reserves the right to request payment in full from our patients for services rendered and let the patient collect the insurance funds that are due to you for any claims that have not been paid within **60 days** of submittal.

I have read, understand and accept the above outlined insurance policy and financial commitments that may occur as a result of treatment at Dr. Seth Roth's office. Please initial_____.

Returned Check-- It is not our policy to automatically redeposit checks returned to us for insufficient funds. We will charge a fee of $30.00 for all returned checks and will require all future payments be made by money order, credit card or cash. Please initial_____.

Financial Options- Our office proudly accepts Visa, MasterCard, American Express, Discover, Care Credit, personal checks and cash. We offer our patients three (3) payment options.

1. Cash, Check, Credit Card
2. Care Credit- We offer Care Credit applications to our patients who may prefer a 12 month interest free budget payment. Please ask our front desk coordinator for further details.
3. 5% Prepay courtesy for our patients with a more comprehensive treatment plan. Any patient who has a co-payment of $500.00 or more is eligible for this courtesy. In order to receive this courtesy payment must be made prior to or on the date of initial treatment.

Please sign below that you have read and understand the Office Policy in place for Seth Roth D.M.D.

Signature___________________________________ Date_________________