Thank You for selecting **Auburn Dental** as your dental provider. We are dedicated to providing your family with quality dental care. Our personnel will be happy to discuss our fees & this policy with you at any time. Please read & sign this form prior to seeing the doctor. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private patients we accept **CASH, CHECK, VISA, MASTER CARD & CARECREDIT**.

***Your insurance policy is a contract between you, your employer & the insurance carrier**. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you & your insurer regarding deductibles, covered charges, secondary insurances & "usual & customary charges".

*We are, however, contracted with most insurance plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims & reimbursements. Any contractual provider discounts will deducted from your balance.

***ALL charges are your responsibility whether your insurance assistance pays or does not pay**. Not all services are a covered benefit in all contracts. Some insurance companies & some employers decide what a covered benefit is & what is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles & co-payments are due at the time of treatment.

*Returned checks & balances older than 90 days may be subject to be sent to our Collection Agency & collection fees which will be charged to the responsible party.

*Please note that ALL cancellations for scheduled appointments must be made at least 24 HRS in advance**. If you fail to cancel your appointment, you will be charged a $25 fee.**

*There will be a **$30 NSF** charge on all returned checks.

*Occasionally an insurance overpayment can occur on your account. Generally this balance remains on your account as a credit for use at a future visit or you may request a refund by notifying our office.

*We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we can assist you in management of your account with an optional payment plan.

Patient Signature: ____ **Date:** ______________

Dr. Shannon Savage- Cerna, DDS 1123 Babcock Suite D SA, TX 78201 PH: (210) 732-8880