Franklin C. Lackee, DDS

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Office Policy

Dear Patient,

We have prepared this letter to help you better understand the complexities of dental insurance, as we realize how confusing it can be. To begin, we would like to highlight the misconception that dental insurance was designed to pay for all dental care that is not the case; it is simply a benefit to assist in making treatment more affordable. Most contracts have limits and/or various degrees of co-payments including deductibles that are the patient's responsibility.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, time, and our constant dedication to provide our patients with the most advanced techniques and highest quality of dental care. Your treatment should not be governed by your insurance contract/company.

It should be understood, however, that the dental insurance contract is between the insurance company and the patient, who ultimately bears the financial responsibility.

*** Please note, that all co-payments and/or deductibles are due at the time of service ***

We hope this information has been helpful. Please take time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask us for clarification of services, billing and insurance.

We do require 24-48 hours notice if you cannot make it to your reserved appointment as there may be a patient in pain who can utilize this appointment, by giving us this advance notice it allows us to fill this spot or have it available for a pending emergency.

- After **THREE** appointments have been missed and/or cancelled without 24 hour notice, you will only be scheduled for same-day appointments depending on availability.

Please be advised that a copy of your signed "HIPAA COMPLIANCE" is available upon request.

Thank you for choosing our office for you and your family and thank you in advance for your understanding and cooperation regarding this policy. We truly appreciate you and all our patients and hope to make this experience the best it can be.

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Patient Signature (parent *or* guardian if under 18 years of age) **Date (mm/dd/yyyy)**