Parkway Dental Office
323 Fox Road
Knoxville, TN 37931

Dear Valued Patients,

We at Parkway dental office take pride in our warm, caring atmosphere. One aspect we really enjoy about our practice is the opportunity to offer quality care and individual attention to each and every patient. We like having that personal time with you. When that time is lost due to an appointment cancellation, other patients in need of treatment cannot be seen and your treatment is delayed. For these reasons, we have the following office policy:

Appointment Cancellation Policy

We will make every effort to remind patients by telephone prior to the appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, pagers, and voice mail, some of our patients are not receiving our reminder calls due to the occasional malfunction of these devices. If you use such devices, we kindly ask that you return our call to confirm that you received our message. If we are unable to contact you directly, your appointment card or appointment phone call will serve as confirmation of your appointment and it implies your obligation to be present. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $36.00 cancellation fee. Future appointments will be denied until the cancellation fee is paid. If commitments for appointments are frequently broken, a non-refundable reservation fee equal to the appointment fee may be required. Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal. Thank you for your cooperation. We look forward to seeing you on your next appointment.

Sincerely,
Parkway Dental

_____
Print Name

_____ _____
Signature Date

TURN PAGE OVER TO CONTINUE

Parkway Dental

PATIENT FINANCIAL RESPONSIBILITY

As a patient of the office of Parkway Dental, I understand that as a recipient of dental treatment, I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. **Full payment is due at the time of delivery of service**. I understand that a fee is charged for **all** office visits, dental examinations, and dental reports. I agree that the determination of the professional services to be rendered by my dentist and the fees to compensate the dental office for these services are matters which concern my dentist and me. I understand that I have the primary duty and obligation to pay my dentist for services rendered, notwithstanding any contract that I may have with any third party payer (i.e., insurance company, employer, etc…)

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorizes this dental office and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to PARKWAY DENTAL all benefits. **I understand that I am financially responsible for all charges incurred**. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. **Any unpaid charges are my responsibility**. Full payment is due at the time of service except if otherwise arranged.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Provide Parkway Dental Office with complete and accurate billing information, including, but not limited to, a current insurance card and authorization numbers. I further understand that I am responsible for all visits and procedures.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

I give my consent to Parkway Dental to provide dental care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my dental condition.

I HAVE READ AND AGREE TO ALL THE TERMS OUTLINED ABOVE

_____

Print Name

_____ _____

Signature Date