

# The Klein Dental Group

## PATIENT POLICIES

We truly appreciate you entrusting us with your dental health. As an office and staff, we pride ourselves on delivering the highest quality care and level of service to our patients. We need your help. To achieve our goals, we have outlined specific appointment and financial policies. It is important that you know and understand these so we can serve you and all our patients to the best of our ability.

### APPOINTMENT POLICY

An appointment in our office is time reserved specifically for you and the doctor or hygienist. To give full attention to you, we do not "double book" our schedule. We also leave room in our schedule for "emergency" patients who have urgent needs. Leaving this open space will create minimal impact on patients who have reserved an appointment.

- If you are unable to make your reserved time, we ask you to call our office during business hours at least 2 business days (48 hours) in advance.
- A "no show" appointment is simply one where the patient does not call our office or leave a message in accordance with the above guideline. Three (3) broken appointments will result in dismissal from the practice.
- On the first no show appointment, we will attempt to reschedule you at a time that's convenient.
- If you are running late for an appointment, we ask that you call us to keep us informed of your estimated time of arrival.

### FINANCIAL POLICY

We gladly submit your insurance claims to your insurance company as a courtesy to you. It is the responsibility of the patient to notify this office of any changes to name, address, phone number and employer. Payment is required at the time of service for all charges not covered by your insurance company, including co-pay and deductibles.

I agree that I will be responsible to pay for any portion of the charges not covered by my insurance, interest may accrue at 1.5% per month.

### NOTIFICATION PERMISSION

By providing your mobile phone number and email address, you grant permission for us (or a third party acting on our behalf) to contact you regarding your Klein Dental account by phone, artificial or pre-recorded voice mail, text, email, or automated dialing technology. Message and data rates may apply.

### ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OR PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I have read, understand, and agree to the above policies.

\_\_\_\_\_  
Patient /Guardian/POA Signature

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date