Dr. Andrew Shelby, DMD, MS
4505 W 6th St. Suite B, Lawrence, KS 66049

FINANCIAL AGREEMENT

The following guidelines have been established for payment of financial obligations for services rendered in our office. Please read carefully and select the payment options most suitable for your situation.

_____ **Check/Cash**
_____ **Credit Card** – Visa / Mastercard / American Express
_____ **Payment Plan** – To be discussed with the Office Manager

If you have dental insurance, please advise our Receptionist or Office Manager at your initial appointment. As a service to you, we will find out your dental claim and/or predetermine your dental benefits. We will do our utmost to assist you in obtaining benefits allowable under your insurance plan. However, you should be aware that *your dental insurance is an agreement between yourself and your carrier*. We are not responsible for any limitations imposed by your insurance carrier. A 1.5% finance charge or minimum of $8.00 will be applied to account balances aged more than 30 days. Returned checks are subject to a $35.00 returned check fee in addition to any bank fees incurred.

I have selected a payment option and understand my financial obligation with this office.

_____ _____
[Signature] [Date]

CANCELLATION & "NO SHOW" POLICY

The following are our policies regarding cancellations and "No Shows". We take this subject seriously as it can make the difference between whether you succeed in your treatment or not.

- **We require 48-hour notice in the event of cancellation.** It is your responsibility, when you call in, to have alternative times in mind that will ensure you get the prescribed treatment.
- **There is a $40 charge** for a "No Show" or cancellation without 48-hours notice with our hygienist for a periodontal maintenance appointment.
- **There is a 25% charge of the total of the appointment** for a "No Show" or cancellation without 48-hours notice for ***any procedure*** scheduled with Dr. Shelby or the hygienist at our office.

When a patient does not show for an appointment, three people are affected: (1) the patient because they do not receive the treatment as prescribed, (2) the dentist or hygienist who now have a space in their schedule since the time was reserved for that patient, and (3) another patient who could have been scheduled for treatment if there has been adequate notice. We will provide a courtesy call to you in advance as a reminder for your appointments, but keeping scheduled appointments at this office are ultimately the responsibility of the patient.

I have read and understand the Cancellation & "No Show" Policy of this office.

_____ _____
[Signature] [Date]

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SIGNATURE ON FILE

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my insurance carriers
- I authorize my dentist to act as my agent in helping me obtain payment from my insurance carriers.
- I permit a copy of this authorization to be used in place of the original.
- I authorize payment directly to my dentist. *
- I understand that I am responsible for my bill.

Name _____
Please Print

Signature _____ Date _____

*This is applicable to individuals who have ***Delta Dental/Delta USA/BKBS*** as their dental insurance carriers. Benefits from all other dental insurance carriers will be sent directly to the insured.