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[www.SmileBismarck.com](http://www.SmileBismarck.com)

### Patient Guidelines

1. Please let us know 24 hours prior to appointment time if you are unable to keep your appointment for any reason. We do have an answering machine for you to leave a message if it's after business hours.
2. Your dental health is important to us and we want you to know how important it is for you to keep your dental appointments. Please do not make an appointment that you cannot keep. If you are consistently unable to keep appointments, we will not be able to continue to reserve time for your dental appointments which may lead to dismissal from our office.
3. Please let us know if you have moved or will be moving. We like to send postcards to let you know when you should come back for your next appointment.
4. Please call to confirm your appointment the day before if you have not heard from us. We try to call, however sometimes we are just unable to reach you, we would love to hear from you so that we can keep the time reserved for you.
5. Please make sure that we have the correct insurance information. Unfortunately, you are responsible for any unpaid claims due to missing/incorrect insurance information.
6. If you do not have insurance and are concerned about the balance on your account, you are required to contact us within 30 days of receiving your statement to set up a financial arrangement.
7. We will file your insurance claims as a courtesy for you and will accept "assignment of benefits" on your behalf. Regardless of what we may calculate your insurance company to pay, it is only an estimate. The financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company. We will do all we can to get the maximum benefits reimbursed for you. Please be aware that some of the services provided may not be covered or may be considered above the 'usual and customary'. You are responsible for payment of your account within 30 days of receiving your statement, regardless of any insurance company's arbitrary determination of usual and customary fees.
8. We will try our best to treat everyone, however sometimes we are unable to treat uncooperative patients.

By signing this you agree and understand the guidelines for either you and/or your family member's dental care.

Name of Patient: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_