D&K TEXAS FAMILY DENTISTRY

Dr Bobby Jivnani DDS PA
670 West Campbell Rd. Suite 120
Richardson, TX. 75080

General Office Policies

_____ Late Arrivals
We ask that you kindly notify our office if you are more than 15 minutes late, it may be necessary to reschedule your appointment to another day or a later time. This will allow us to honor our time schedule for the day.

_____ Appointments for Minors
Parents or guardians must accompany minors for all dental visits. Treatment will be denied for any unaccompanied minors.

_____ Payments
Payment for dental treatment is due in full on the day of your scheduled appointment. This does not include your Dental Cleanings, Exams and X-Rays if covered at 100% with your dental insurance carrier.

_____ Cancellations
Please verbally contact our office 48 business hours in advance of any schedule changes. This will allow us reasonable time to reschedule that open appointment time slot.

_____ No Show
If you miss your appointment with no previous notice to our office, a $75.00 fee may be applied.

_____ Returned Check Fee
Any returned checks are subject to $35.00 service fee and will also be turned over to a collections department if not taken care of within 7 business days. We will also no longer accept checks for payment in the future.

_____Monthly Credit Card Charges
If charges do not go thru as agreed, additional $25 will be charged for each time a credit card is declined.

Insurance

As a dental care provider, our relationship is with you, our patient, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. We will make every effort to collect benefits from the insurance company, however if the claim is not paid within 60 days, you will be responsible for the outstanding balance.

We thank you for understanding our office policies. Our goal is to make your visit with us as pleasant and professional. If you have any questions, please feel free to ask our staff for assistance. Thank you for choosing us for your dental care.

Acknowledgement

In consideration for the professional services rendered to me by the Doctor, I agree to pay therefore the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____Date:_____Relationship to Patient:_____

Signature of Patient, Parent/Guardian