Office Policies
Dr. Joel Sanders, D.D.S.
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It is a pleasure having the opportunity to take care of your dental needs in our office. We make every possible effort to keep our fees at a reasonable rate. To ensure the highest quality dental care and personalized service, we'd like to share our office policies with you.

- **Unless prior arrangements are made with the office manager, a payment in full is due at the time of service.** We accept credit card payments.
- To maximize the efficiency of your financial account, we are ready to assist you in submitting your dental insurance claims. We'll accept assignment of benefits from most carriers, including PPO plans. However, your dental insurance plan is a contract between a particular insurance carrier and your employer (or yourself), and we do not have any control over the amount of coverage provided. If you have assigned our office to receive your dental benefits directly –
    a) **A payment of 30% will be due at the time of service for all direct restorations done in office**.
    b) **A payment of 50% will be due at the time for service for all permanent restorations such as crowns, onlays/inlays, dentures or bite guards that are laboratory fabricated.** (The dental laboratory that we work with requires one-half of the total fee for all work, to be paid at the time of submittal.)
    c) It is your responsibility to satisfy any balance on your account left unpaid by the insurance carrier.
- We do our best to remind you by telephone of appointments. But please, do not depend on this courtesy. If we are unable to contact you, your appointment card will serve as the confirmation and implies your obligation to be present. This time has been reserved especially for you.
- **If you feel you need to change your appointment, we require at least 48 hours prior notice to avoid charging you for our lost time, as well as to make the time available to other patients.**

Thank you for choosing our office. We look forward to taking care of your dental needs. If you have any questions, please feel free to consult with our staff.

Your signature below indicates your understanding and willingness to comply with our office policies.

Patient or Guardian

Signature______________________________________ Date: __________________