PETER W. MOHN JR. D.D.S., P.C. OFFICE AND FINANCIAL POLICY

Dr. Peter W. Mohn Jr. D.D.S., P.C.
700 Branch St. Ste. 7
Platte City, MO 64079
O: 816.858.2707
F: 816.858.5005
officemanagermohndds@gmail.com
Contact Person: Cydney Ham

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, MasterCard, Discover and Care Credit. Returned checks will be subject to additional fees.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. **If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.**

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation we require 48 hours advanced notice. This will allow us to fill your appointment with other patients who are waiting to be seen. **If you fail to keep your scheduled appointment and to not provide sufficient notice, we reserve the right to bill you for that time. $25 for each hour scheduled.** Three missed appointments may result in dismissal as a patient.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Doctor to take X-rays, photographs, or any other diagnostic aids deemed appropriate by Dr. Mohn to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Mohn to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

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Signature (Patient or responsible party) Date