integrative oral medicine
DOUGLAS G. THOMPSON DDS

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FINANCIAL AND APPOINTMENT AGREEMENTS

We are pleased that you have selected Integrative Oral Medicine/Dr. Doug Thompson and his team to provide your health care services. Please read this financial agreement carefully so you understand and agree to abide by the payment terms outlined below.

We ask for payment when services are rendered, however, most dental insurances can be used to offset treatment costs. We complete all insurance paperwork on your behalf. We are not involved in any insurance discount programs or programs that mandate that we accept the insurance company's determined amount for services. It is ultimately your responsibility to pay for services rendered regardless of the limitations of your insurance plan. Dr. Thompson and his entire team believe in discussing fees for recommended services in advance so you understand your financial obligations. For your convenience we accept cash, checks, most major credit cards and Care Credit.

In addition to our financial agreement, it is also important to understand our cancellation and broken appointment agreement. We are aware that sometimes emergency circumstances arise that cause unexpected schedule changes. We reserve hygiene and doctor time, including staff support, exclusively for you, and missed appointments cause a scheduling and financial burden for all of us.

- We require a minimum of 48 hours notification of any cancellations. After one cancelled or broken appointment without 48 hours notification, we will review this agreement with you in letter form.

- After a second time, we will require you to "reserve" your next appointment with a credit card or other method of prepayment, to hold the appointment time. Our minimum reservation charge is $125. By honoring your agreed upon reservation your deposit will be applied to any services provided. Should you fail this reserved appointment, your deposit will be used to offset our costs.

- Prepayment for future appointments will be determined on a case by case basis.

I understand and agree to abide by the administrative agreements outlined above.

Patient Name: _____

(Print) (Signature and Date)