J. Peter St. Clair, DMD
FAMILY & ESTHETIC DENTISTRY

151 Central Street | Rowley, MA 01969 | 978.948.2030
www.stclairdmd.com

OFFICE POLICIES

Please read this very carefully.

APPOINTMENT POLICY

Appointments made in our office are considered firm obligations. Our office is open Monday through Thursday. If your appointment is scheduled for a Monday, it must be changed by Thursday of the previous week.

We realize life happens. However, we keep strict track of all appointment changes. We reserve the right to terminate our relationship at our discretion.

**We request 48 hours for any appointment change.*
**Any changes to an appointment, within 24 hours, is considered a broken appointment.*
**We reserve the right to charge a fee (an example would be $50.00 per half hour of scheduled appointment time, to cover administrative costs.*
(2) **FAILURE TO SHOW appointments results in termination of our relationship.*

☐ *I hereby acknowledge that I have read and fully understand this Appointment Policy.*

Signature of Patient/Responsible Party: _____

☐ *Refuse to sign.*

DENTAL INSURANCE

As a courtesy to our patients, we will submit claims to your insurance company for services provided. You and your insurance company share responsibility for your fees.

Although we do verify eligibility by phone and online, we do so for our own business purposes and the extent of our verification is limited to current eligibility, yearly benefit maximum, yearly deductible, and general benefit level. We are not responsible for knowing or inquiring about the specific clauses with your policy such as waiting periods, in network or out of network benefits, etc. If you are not sure of your specific benefits or coverage, we encourage you to contact your insurance carrier.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient/Responsible Party: _____

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of J. Peter St. Clair, DMD's Notice of Privacy Practices has been posted online: www.stclairdmd.com.

☐ *I hereby acknowledge that I have been given access to this practice's Notice of Privacy Practices, by the link above. I acknowledge that I am encouraged to contact the office with any questions I may have regarding this notice, by calling 978.948.2030.*

Signature of Patient/Responsible Party: _____

☐ *Refuse to sign.*

Continued on Page 2

FEES & PAYMENTS

We realize that even if you do have dental benefits, there is usually a balance, which is your responsibility. We also know that patients who choose our care, do so because they realize the service provided is worth the investment in their health.

We are very reasonable and have many financial options available to help make your care affordable to you.

☐ *I hereby acknowledge that I agree to engage in and fulfill financial contracts with this dental office prior to any dental services performed.*

Signature of Patient/Responsible Party: _____

☐ *Refuse to sign.*