ROBIN C. ARDOIN, D.D.S.,PH.D.
HAROLD D. KENNEDY, D.D.S.

OFFICE AND INSURANCE POLICY

We would like to take this opportunity to welcome you to our office. Your comfort and well being are our main concern. If you have any questions, please feel free to ask for our assistance.

Please be advised that this is a surgical office; therefore, due to emergencies and unforeseen circumstances, delays may occur. However, we will make every effort to see you at your scheduled time.

At Dr. Ardoin and Dr. Kennedy's office, we make every effort to provide you with the finest surgical care and the most convenient financial options. To accomplish this goal, we work hand with you to maximize your insurance reimbursement for covered procedures. If you have any problems or questions regarding your insurance please ask our staff and we will be happy to assist you. It is important to be informed that if you are covered by dental/or medical insurance our professional services are rendered and charged to you and not the insurance company. As a courtesy to you, we will file your insurance for you to be reimbursed for these services. Our doctors are not on and do not participate with any medical plans including Medicare. If you are on any type of HMO that requires referrals, it will be your responsibility to obtain them. WE URGE YOU TO BE FULLY AWARE OF THE PROVISIONS OF YOUR POLICY. PLEASE INFORM OUR OFFICE IF YOUR SURGERY NEEDS TO BE AUTHORIZED/OR A PRE-DETERMINATION NEEDS TO BE SENT TO YOUR INSURANCE COMPANY PRIOR TO SURGERY. IF GUIDELINES BY YOUR INSURANCE POLICY ARE NOT FOLLOWED, A PENALTY MAY APPLY WHICH WOULD RESULT IN A REDUCED REIMBURSEMENT. ANY OVERPAYMENT ON YOUR ACCOUNT WILL BE REFUNDED TO YOU IN A TIMELY MANNER.

PLEASE REMEMBER YOUR ARE FULLY RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE REGARDLESS OF YOUR INSURANCE COVERAGE.

Should any unpaid account balance be turned over to an agency or attorney for collection, all fees and court costs shall be chargeable to the responsible party. Any closed account and/or NSF checks will result in a $25.00 fee. Our payment policy includes: cash, check, Visa, MasterCard, Discover and Care Credit. Payment is due at the time the services are rendered.

Kindly provide 24 hour notice of cancellation. Failure to do so may result in a $50 to $100 missed appointment charge.

Thank you for your cooperation and we appreciate you choosing this practice for your surgical needs.

I have read and understand this policy.

X_____

Signature of Patient or Responsible Party Date