

Office Policy of Lyons Family Dentistry

806 Farnsworth Avenue Bordentown, New Jersey 08505 609-298-8309

Our office mission is to make our patients feel and look their very best through excellent dental care provided by our team.

- _____ 1. **Treatment Area:** No one besides the patient will be allowed in the treatment room unless absolutely necessary. This is required by safety regulations.

Cell phone use in the operatories is prohibited due to possible interference with our equipment.

- _____ 2. **Appointments:** This time is reserved especially for you. We value your time and we ask the same in return. Any change in this appointment affects many people. Therefore, we ask you to please provide us with 24 hours notice if you are unable to keep your appointment.

- _____ 3. **Financial Responsibility:** As a courtesy, we will submit your insurance claims. You are responsible for your estimated co-pay at the time of service. Any remaining portion unpaid by insurance will become your obligation.

Please mark which method of payment you will be using:

Cash _____ Checks _____ Credit Cards _____

Interest free payment plan: Care Credit _____

Returned checks: An assessment fee of \$50 will be made for a returned check, plus a bank fee of \$15. A cash or credit card payment will be expected before another appointment can be scheduled.

- _____ 4. **Courtesy:** Senior patients without insurance will receive a 10% courtesy.

- _____ 5. **Right of Access:** All requests for records will be dealt with promptly at no charge.

- _____ 6. **Consent for Treatment:** For routine dental x-rays, exams, perio charting, and cleanings, the undersigned hereby consents to examination and treatment of the patient by members of the dental staff of Alina E. Lyons, D.M.D., P.A., Family Dentistry to preserve or improve the patient's health status.

- _____ 7. **Authorization to Release Information:** I hereby authorize the dental group to release information and signature on file concerning the examination and treatment of the patient to any insurance company requesting information for the purpose of determining eligibility of insurance to Alina E. Lyons, D.M.D., P.A., Family Dentistry.

Signature: _____ Date: _____