Lyons Family Dentistry

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806 Farnsworth Avenue • Bordentown, NJ 08505
(609)298-8309

Office Policy of Lyons Family Dentistry

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Patient Name: _____ _____ ____
Last First MI

_____
Preferred Name

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: Only the patient will be allowed in the treatment rooms. Unless absolutely necessary. This is required safety regulations.**

☐ **2. Appointments: Your appointment time is reserved especially for you. We value your time and ask the same in return. Any changes in your appointment affects many people. Therefore, we ask you please provide us with a minimum of 48 business hours notice if you are unable to keep your appointment. Without proper notice you will be charges a $150 fee.**

☐ **3. Financial Responsibility: As a courtesy, we will submit your insurance claims. You are responsible for your estimated co-pay when you schedule your appointment. Any remaining portion unpaid by your insurance will be your responsibility.**

Please check which method of payment you will be using:

☐ Cash ☐ Check ☐ Credit card ☐ Care Credit

Returned Checks: An Assessment fee of $50 will be made for a returned check, plus a bank fee of $35. 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, periodontal charting, and cleanings, the undersigned hereby consents to examination and treatment of the patient by members of the dental team of Lyons 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 fileconcerning the examinationand treatment of the patient to any insurance company requesting information for the purpose of determining eligibility of insurance to Lyons Family Dentistry.**

☐ **By Checking this box, I acknowledge that I have read this statement and agree to the contents.**

Response Date: _____