OFFICE POLICIES UPDATED 2025

Thank you for choosing Glowing Smile Dental Studio for your dental needs. We are committed to providing quality dental care for your entire family in a friendly and caring environment. The following is a summary of our office policies for your review. We will be happy to answer any questions you might have about our policies.

Appointments

We are dedicated to staying on schedule and seeing all of our patients on time for their appointments. We do ask that our patients arrive on time for their scheduled appointment. We recommend arriving 5-10 minutes early so that you can check in and fill out any additional information that might be needed. Please be aware that dental emergencies or restorative delays could occur at times and this can cause a delay in your appointment. We are committed to advise you immediately if there is a sign of delay to your appointment.

Reserving Treatment Appointments

Our office requires a deposit to hold appointments for treatment with the doctor or specific hygiene appointments with our hygienist. This deposit will be required at the time of scheduling as an appointment reservation fee. Deposits will be credited towards your treatment at the time of the appointment. Rescheduling or failing to show up for your appointment without 48 BUSINESS HOUR NOTICE AND BEFORE FRIDAY'S 3:30PM CLOSING, will result in a loss of your deposit, UNLESS YOU HAVE A DOCTOR'S EXCUSE.

$50.00- $500.00 non-refundable appointment reservation fee for treatment appointments that are canceled. If patients need to reschedule, we require a 48 BUSINESS HOUR NOTICE, AND BEFORE FRIDAY'S 3:30 PM CLOSING OR patient(s) will lose deposit made and/or broken fees, $50.00 will be applied.

Late Policy

We expect our patients to arrive on time for their scheduled appointment. If you arrive 15 minutes late for your appointment, you may be asked to reschedule for another day/time. This will be based on the amount of time we have scheduled for your appointment and if we are able to complete your appointment without causing delay to proceeding appointments.

Cancellations

We reserve time especially for you. If you need to change your appointment, we ask for a minimum notice of 48 business hours, AND BEFORE 3:30PM, FRIDAYS.. Glowing Smile Dental Studio reserves your appointment time exclusively for you. We do not "double-book" or keep

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extra patients waiting in case you don't come to your appointment. It is critical we are notified if any changes to your appointment needs to be made.

1ST missed/ cancelled* appointment: WILL BE CHARGE $50 BROKEN APPOINT FEE UNLESS YOU HAVE AN EXCUSE FROM A DOCTOR.

2nd missed/cancelled* appointment: Your account will be charged $50.00 the late cancellation/ missed appointment fee for any missed or rescheduled appointments within less than 48 business hours. FRIENDLY REMINDER THAT WE CLOSE FRIDAYS AT 3:30 PM THEREFORE, PLEASE CALL TO CANCEL/RESCHEDULE BEFORE THAN.

3rd or more missed/ cancelled* appointments: Patients who excessively miss their appointments may be formally dismissed from the practice and will be charged the late cancellation/ missed appointment fee.

**** WE HOPE THAT YOU UNDERSTAND OUR POLICY REGARDING CANCELLATIONS/RESCHEDULING*****

Weekend and After Hours

Patients of record with true dental emergencies after regular business hours should call our AFTER HOURS LINE, 863- 651-7443 for information on how to contact one of our doctors. Our office does not have an on-call dentist to see patients during these times. We will assist you as best as we can during this time. If patients require to be seen immediately during off hours, we will inform you to visit an urgent care dentist or hospital.

Financial/Insurance Policy

- **Patients without insurance coverage:** The fee for service must be paid in full on the day of service as well as the 1 starting date of service.
- Patients with insurance coverage: The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service as well as the 1st starting date of service. **Please understand that you are ultimately responsible for all fees generated by your insurance AS INSURANCE IS ALWAYS ONLY AN ESTIMATE.** You are responsible for knowing your insurance coverage before your appointment.
- **Patients with dual insurance:** We estimate your treatment with your primary insurance and will assist in filing both insurances. Any credits after both insurances have cleared will be refunded back to the patient or guardian.

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PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We never guarantee what your insurance will or will not pay with each claim.

******We accept Visa, MasterCard, American Express, Discover, Care Credit, and cash for payment of the amount due. We do not accept checks.**

Collections

Any account that has not received payment in 90 days will be handed over to a 3rd party collection agency that will pursue the responsible party for reimbursement. Any charges incurred during this process will be added to the account balance.

Refund

All refunds will have a 5% processing fee AND loss of deposit(s).

Parents of Minors

By signing below, you are agreeing to be the responsible Guardian for the minor's account and balances. Legal parents/guardians must be at all treatment appointments. Due to HIPAA parents/ guardians will not be permitted to accompany patients on the chair. Guardians will be presented any proposed treatment and brought to the back if needed. . Minors coming for exams may come with an authorized adult. Forms must be submitted to the office prior to arriving at the appointment.

Divorce/Separation Parents

The parent authorizing the treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We are unable to place a parent or guardian on an account, as the responsible party, without the express, written authorization from that parent.

By signing below you have read and agreed to our office policies.

_____ _____

Patient signature/legally authorized representative Date

_____ _____

Printed name if signed on behalf of the patient Relationship

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