



31381 DOGWOOD ACRES ROAD, UNIT 2
DAGSBORO, DE 19939

PHONE: 302-732-3852

FAX: 302-732-3855

KEVIN H. BRAFMAN, D.D.S.

WENDY WILSON BRAFMAN, D.D.S.

ASHLEY BANKS, D.M.D.

OFFICE FINANCIAL POLICIES AND PROCEDURES

Patient Name (PLEASE PRINT): _____

- 1.) Any appointments cancelled without **24 hours notice** or a broken/missed appointment may result in a fee charged between **\$75.00 to \$150.00** depending on the length of the scheduled appointment. If a patient misses multiple appointments in the office they may be placed on a "Same Day Only" appointment status. This decision will be made at the discretion of the Doctors. Any fee must be paid prior to rescheduling the patient or any other family members on the account. Your insurance company will not cover this expense.
- 2.) Appointment confirmation is required by all patients. Not confirming your appointment could result in being removed from the schedule and charged a missed appointment fee. We require that all appointments are confirmed, at minimum, by 9am the day before the scheduled appointment.
- 3.) If you do not arrive within **15 minutes** of your scheduled appointment time, you may be rescheduled for another day.
- 4.) While we make every effort to schedule you with your preferred dental Hygienist, circumstances may arise where you could be seen by a different provider. It is possible that we may not be able to notify you prior to your visit. Canceling your appointment due to these rare and unforeseen circumstances will result in a missed appointment fee.
- 5.) Our Doctors require radiographs annually as part of your dental examination.
- 6.) A parent or legal guardian must accompany all children for the initial visit. We require a signed consent and medical history before any treatment will be performed.
- 7.) Payment is expected at the time of service. We will file your insurance claim; however, your estimated portion will be collected at the time of service. The patient is responsible for any service not covered by their insurance company. Any claims that are more than 60 days past due will become the responsibility of the patient.
- 8.) There is a **\$35.00** returned check fee.
- 9.) Any account sent to collections will be charged an additional fee up to 50% of the outstanding balance and any processing or court fees.
- 10.) In the event of a weekend **emergency** please call the **Doctor's pager number at 302-441-3852**. This is a service for "True Dental Emergencies", and only for patients that have been currently seen in our office. There may be a charge applied for this service.
- 11.) There is a **\$20.00** duplication fee for the transfer of dental records and radiographs per patient. A completed signed release by the patient or guardian is required prior to the release of the records. The office will contact you once the records have been prepared.

I have read and understand the above, and I agree to be responsible for payment of all services rendered and any billing/collection fees accumulated on the patient's account.

Name of Patient (Parent/Guardian if Minor) / Responsible Party
(PLEASE PRINT)

Social Security Number of Responsible Party

Signature of Patient (Parent/Guardian if Minor)/Responsible Party

Date

Signed at: Brafman Family Dentistry, P.A. 31381 Dogwood Acres Road, Unit 2, Dagsboro, DE 19939