Avanti Dental Care
900 S. Main Street, #201, Longmont, CO 80501
Family Dentistry
Phone (303) 776-9701

On behalf of my staff and myself I would like to **welcome** you to our practice. We are happy that you have selected our office for your dental care. We would like to share our office philosophy with you. Our goals are:

1. To provide the highest quality of dental care in a comfortable and gentle manner, resulting in an improved quality of life for you.
2. To educate you so that you can participate in maintaining good oral health.

Insurance / Payment Policy

Dental benefits plans are offered from a number of sources, and vary widely. Therefore:

1. We **won't know** how much your insurance will pay until we actually receive their payment.
2. Please **read** your benefits booklet or **call** your insurance company to learn your expected level of coverage.
3. At the time of service we require cash or credit down payment of **20-50%,** depending on your **estimated** insurance coverage for the procedure.
4. Insurance payments are based on "usual and customary" fees. These fees are traditionally lower than average charges. Therefore, you are **responsible** for any remaining balances.
5. After we receive insurance reimbursement, we will notify you if you owe an additional payment, or are due a refund of overpayment.
6. Financial arrangements are available through an outside financial service.

Missed Appointment Policy

We understand that life gets hectic, and scheduling conflicts may arise. If you find you must change or cancel an appointment, please notify our office as soon as possible, but **no later than 24 hours in advance** so that we are able to fill the open time slot. Your appointment time has been reserved for **you**. If you cancel without 24 hours notice, or you fail to show for your appointment, **you will be billed $50.00.** In addition, you **will no longer be allowed to schedule your appointments in advance.** Future appointments will be allowed on a day by day basis. You must call on the day you wish to be seen and if our schedule permits, we will be happy to provide treatment.

It is important that you value our time; just as we will value yours.

HIPPA Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices for Avanti Dental Care, P.C.

Patient's Signature: _____ **Date:** _____