

Practice Policies: Terrific Smiles of the Palm Beaches

Miriam Rubano, DMD, PLLC
1825 Forest Hill Blvd. Suite 206
West Palm Beach, FL 33406
Office: 561-433-9694
Fax: 561-433-8616

Terrific Smiles of North Palm Beach, LLC
721 US Highway 1 Suite 106
North Palm Beach, FL 33408
Office: 561-494-0299
Fax: 561-840-8599

Welcome to our practice. We are here to provide our patients with an exceptional dental experience. If you have any questions about any of these practices, please feel free to ask us for further clarification.

FEES: Our fees are based on the high quality of the dentistry and the exceptional values of the service we provide. To provide this high level of quality, we use only the very best quality materials and products available. We would rather justify our fees than have to apologize to you for providing poor quality dentistry.

MISSED APPOINTMENTS: We ask that if you can not make a scheduled appointment that you call at least 24 hours in advance on weekdays and 48 hrs advance for weekends to cancel. There is a \$25 fee for missed appointments that are not canceled by calling or leaving a message on our service on weekdays. The fee is \$50 for weekend appointments.

AFTER-HOUR VISITS: If you have a dental emergency or request an appointment after normally scheduled hours, we will try to accommodate your needs, but you will incur a **\$150 after hours fee**. If you call during normally scheduled hours and we are booked until the end of the day, we reserve the right to schedule you at the end of the day but you may be charged the after hours fee if we need to keep the office open for extra time. We try to avoid after-hours emergencies by encouraging our patients to follow through with recommended treatment. We are open most Saturdays and some evenings, but an appointment is required at least 2-3 weeks ahead of time. If you request a Saturday and/or evening appointment sooner and we need to extend our hours to accommodate your request, then you may be charged an after hours fee.

PAYMENTS: Unless prior financial arrangements have been made all charges are due in full at the time of service. For your convenience we accept cash, check, VISA, Master Card, Discover Card & American Express. A low monthly payment plan is also available for qualified patients, please inquire for details. You are ultimately financially responsible for your account balance.

WARRANTY: We stand behind the high quality of the dentistry we provide. The long-term success of the dental treatment we provide is dependent upon how you care for your teeth & gums. This includes brushing, flossing, regular dental exams, regular professional cleanings, re-care visits and other prescribed treatment. If you do your part we will always do our best to help you, but we offer no warranties or guarantees, written or verbal, of any kind.

INACTIVE PATIENTS: Patients that have not had regular exams and professional cleanings for a period of one year (12 months) will be considered inactive. Inactive patients that wish to continue treatment may have to start the treatment process again as a new patient depending on the amount of time they were inactive and the current state of their dental health. Due to space limitations, records for inactive patients are sent to off-site storage. Once your records are sent to off-site storage, a \$25 record retrieval fee will be charged if we must retrieve your records for any reason. Copies of records are available at the fee regulated by the state of FL.

INSURANCE COVERAGE: The insurance contract is between you and your insurance company. We are participating providers with many insurances and if we are out of network, we may accept "Assignment of Benefits" from your insurance company. We estimate the portion of the charges that your insurance company will pay & file a claim with the insurance company for you. The remaining portions of the charges are due in full at the time service is provided. It is your insurance company that makes the final determination of your eligibility & benefits. We have no control over your insurance contract. If after 30 days we have not received payment from your insurance company, or if the payment we received is less than estimated, we will bill you. You are ultimately financially responsible for your account balance. If we experience difficulties with your insurance company we may discontinue accepting "Assignment of Benefits". Resubmitting claims adds to our administrative burden which increases our operating costs. If we must resubmit a claim to your insurance company your account will incur a **\$10 claim resubmission fee** for each resubmission.

ADDITIONAL FINANCIAL POLICIES: Account balances over 30 days old will be considered past due. We will attempt to contact you and/or send you a statement to resolve past due account balances. Account balances that are not paid full within 60 days of the date of service will incur a \$25 late charge & will be promptly turned over for collection action. If your account balance becomes past due, we will take all necessary steps to collect this debt. If we have to refer your account to a collections agency, you agree to pay all incurred costs. In case of suit, you agree the venue shall be in the West Palm Beach, Florida & Palm Beach County, and you agree to pay all legal fees. In case of divorce or separation, the party responsible for the account prior the divorce or separation remains responsible for the account. **Returned Checks:** All returned checks will be subject to the maximum service charge allowable by state law and will be promptly turned over to the State of Florida's State Attorney's Office for legal action.

TREATMENT REFUSAL: We reserve the right to refuse treatment or discontinue treatment to anyone for or discontinue treatment to anyone for any reason, including but not limited to, violations of these policies. We can make referrals to other health care providers if requested.

I, the undersigned, have carefully read & fully understand the office policies of Miriam Rubano, DMD, PLLC as described above & do hereby agree to the terms & conditions set forth within. I fully understand my obligations & financial responsibilities as a Patient or the parent/guardian of a patient of this practice.

Signed: _____ Date: _____