John M. Schiefelbein, DMD, PLLC

Office Policy

We respect the importance of your time and work hard to schedule appointments that accommodate the busy scheduling needs of all our patients.

- We value your time and ask that you value ours by arriving on time for all appointments
- We request 2 business days' notice to cancel or change an appointment and reserve the right to charge your account $75 if not notified at least 24 hours before your appointment
- After 3 broken appointments, we are unable to see you in our office for your dental needs

Payment is due at time of service and we offer the following payment options:

- ***Cash, Check, Visa or Mastercard***
- ***Care Credit***
- We work with most dental benefit plans

Patients with Dental Insurance:

- We will submit to your dental insurance and do our best to verify dental benefits prior to your first appointment; however, this does not guarantee coverage or payments to John M. Schiefelbein, DMD, PLLC.
- It is the responsibility of the Patient/Insured Policy Holder to contact our office with any changes to their Insurance Policy or coverage.
- Your estimated portion not covered by insurance is due the day services are provided. There may be a residual balance even after your estimated portion is paid and after insurance pays. All services are due to be paid in full within sixty (60) days of date of service, whether or not insurance benefits have been received.

Authorization to Release Information And Assignment Of Benefits; I certify that I, _____, (or my dependent) have(has) dental insurance coverage and assign directly to John M. Schiefelbein, DMD, PLLC all insurance benefits, if any, otherwise payable to me for any services rendered. I hereby authorize the doctor and/or his staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

We reserve the right to charge a $5.00 per month billing charge on all past due accounts.

John M. Schiefelbein, DMD, PLLC, reserves the right to update and make changes to the above-stated office polices at any time without prior notification.

By signing below, I verify that I understand, agree and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Print name: _____ Date: _____

Signature: _____

Relationship to Patient if patient is a dependent: _____