J. Robert Hendricks, DMD, MPH
Brentwood Dental Specialists, LLC
1642 Westgate Circle
Brentwood, TN 37027
(615) 373-9889

OFFICE PAYMENT POLICY

- As a courtesy to our valued patients that have insurance plans, our office will check eligibility, benefits and file insurance claims for reimbursement for all rendered dental services. ***However, eligibility and financial reimbursement from your insurance company is NOT a guarantee of coverage and reimbursement, as actual benefit payments are determined only when a claim is processed by your insurance company. Therefore, if the estimated portion of third party payment does not fully reimburse for the dental treatment rendered, the financially responsible person is responsible for the remainder of the balance.***
- Co-payments, deductibles and estimated payment portions for our accepted insurance plans are DUE in full at the time of dental treatment.
- For orthodontic appliances (space maintainers, expanders, retainers, etc.) our office requires a 50% deposit before they are fabricated and the remaining 50% is due when appliances are delivered, if appliances are not covered by insurance.
- A $50 office fee will be assessed to the financially responsible person and/or guardian in the event that accepted and scheduled dental treatment is unable to be completed due to non-compliance and/or uncooperative behavior by the patient as well if sedative medication is spilled by the parent or child and more medication must be prepared.
- Broken appointments (no call/no show and without at least 24 hours notice) will be charged $25 for each sibling after the second occurrence, to the financially responsible person and/or guardian, if not prohibited by insurance company.
- This office reserves the right to request a refundable deposit for scheduling more than one child for consecutive appointments for the same day.
- There will be a $25 fee charged for any returned checks (insufficient funds). If necessary, a collection agency will be employed to collect overdue accounts and the collection fee will be charged to the patient's account. Consequently, credit agencies will be notified of delinquent accounts.
- This office reserves the right to discontinue treatment/cancel all future appointments of any patient (or family) who has cancelled, failed or we are unable to confirm scheduled appointments for THREE scheduled appointments. Your insurance company may be notified of your discontinued treatment.

I, as the financially responsible person and/or guardian for this account, certify that I have read, understood and agreed to this office policy.

_____
Patient Name

_____
Signature of Parent/Guardian

_____
Date