

# KITT DENTAL

DR. PARRIS KITT

10752 FM 2813 FLINT, TX 75762

Phone: 903-561-4477 ~ Fax: 903-561-4475

## Payment & Financial Policies

As a service to our patients, we will file insurance claims on your behalf for services rendered in our office. However, please read, understand, AND initial the following:

The patient or patient's guarantor is responsible for all charges incurred in our office.

### **Patients with NO DENTAL INSURANCE- CASH PAY:**

\_\_\_\_\_ Payment is due in full upon services rendered unless other payment arrangements have been made PRIOR to treatment.

### **Patients WITH DENTAL INSURANCE coverage:**

\_\_\_\_\_ We can only estimate what your insurance will pay for services rendered.

\_\_\_\_\_ Your dental insurance is a contract between you (the patient or guarantor) and the insurance carrier- not Kitt Dental or Dr. Kitt.

\_\_\_\_\_ Any payments received by Kitt Dental from your insurance company will be credited to your account; however, after 60 days all outstanding balances are the responsibility of the patient or the patient's guarantor.

## Cancellation & Communication Policy

We want you to be here! In fact, we set aside a very special time just for YOU! If for any reason you know that you cannot make your appointment, please give us at least a 48 hour notice so we can make an attempt to fill that time.

To help remind you of any future appointments, we send out email reminders two weeks before the appointment and a text message reminder one day before.

(This will NOT apply to you if you selected NOT to receive emails or text message reminders on the first page of the patient information sheet.)

Please realize IF you do not reply to the reminders received, we will call you to confirm your appointment.

The BEST number to reach you at between 8am-5pm is \_\_\_\_\_.

Is it okay to leave a detailed message at the phone number listed above?    Y    N

## NOTICE OF PRIVACY PRACTICES

**I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.**

Print Patient Name: \_\_\_\_\_

Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_