DAVID M. REESE D.D.S., P.A.
GREG SIMON D.D.S.
Family Dentistry
607 Front Street Conway, AR 72032
Phone (501)327-2586 Fax (501)329-8934

PLEASE READ CAREFULLY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

At the time of your initial visit further treatment may be needed. If so, you will be scheduled for an appointment and given an estimate for the needed treatment. **ALL FEES QUOTED ARE ESTIMATES AND ARE SUBJECT TO CHANGE DEPENDING ON THE NATURE OF TREATMENT NEEDED.**

UNACCOMPANIED MINORS
The parents (or guardians) are responsible for full payment at the time of service. Non-emergency treatment may be denied unless charges have been preauthorized to an approved Visa, Master Card, Discover, American Express, Care Credit or paid by cash or check at the time of service.

MISSED APPOINTMENTS
Unless cancelled at least **24 hours in advance**, you will be subject to a failed appointment charge. **Please help us serve you better by keeping scheduled appointments.**

Signature_____Date_____

PATIENTS WITH INSURANCE
It is our goal to help you receive the maximum benefits allowed through your insurance plan.

Insurance plans are accepted after proper verification and approval from our office staff prior to treatment. If we accept your insurance, you will be responsible for any deductible and co-payment of total charges (unless estimated coverage is 100%) at the time of service. If your insurance plan has not paid the FULL BALANCE WITHIN 45 working days, and your claim does not require further verification from our office, you are required to pay the balance within 30 days after notification. If your insurance plan pays more than the balance due, we will credit your account unless a refund is requested.

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Signature_____Date_____