James C. Catt, DMD

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AUTHORIZATION OF OFFICE POLICIES, DR. JAMES C. CATT, DMD.

Patient Name: ______________________ ______________________ ___ ________________

Last First MI Preferred Name

Policy Benefits/Non-Covered Charges: I understand that it is my responsibility to know my insurance policy coverage and benefits and will notify Dr. James C. Catt, DMD of any changes in a timely manner, (Many insurance companies have additional stipilations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Services rendered may be considered not covered by insurance and/or may be subjest to a deductible.) I understand that I have the right to refuse any services before they are rendered.

◯ Yes ◯ No

Account Balances: I understand that if I have a balance on my account I will receive monthly statements until the account is paid in full. Bills are due and payable upon receipt of this monthly statement. Dr. James C. Catt, DMD will bill my insurance for me if I provide the appropriate billing information. My insurance will make payment directly to Dr. James C. Catt, DMD (unless previously arranged with the Office Manager) and I will be responsible for any deductible, co-payments, patient balances or co-insurance.

◯ Yes ◯ No

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency if we have not received payment and/or a response to our letters. Please contact us before this if you would like to set up payment arrangements.

◯ Yes ◯ No

Cancellation and No Show Policy: I understand that I will be charged a $50 Cancellation Fee if I fail to notify Dr. James C. Catt, DMD of a cancellation at least 24 hours before my scheduled appointment. Your appointment time is reserved for you. In order to better serve our patients we ask that you call our office at least 24 hours prior to your appointment. Please help us to help others.

◯ Yes ◯ No

Signature: By signing this Office Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above policies.

Signature ____ **Date** __________

Response Date: __________