FINANCIAL POLICY & APPOINTMENT AGREEMENT

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

Thank you for choosing Lakeside Dental. Our goal is to provide exceptional dental care in a transparent, respectful, and efficient manner. To help us provide the best possible experience for every patient, please review the following financial and scheduling policies.

APPOINTMENT CONFIRMATION & ARRIVAL POLICY

As a courtesy, we may contact you by phone, text message, email, or other electronic communication to remind you of upcoming appointments. Confirming your appointment helps us reduce unnecessary reminder messages and allows us to reserve time efficiently for all patients. **Failure to confirm an appointment may result in the appointment being released and rescheduled.**

Your scheduled appointment time is the time we anticipate seating you and beginning your treatment. To ensure your appointment starts on time, **please arrive 5–10 minutes early**. If you need to update your medical history, insurance information, or patient forms, please **complete them before your appointment or arrive at least 20 minutes early**.

We understand that delays and emergencies occasionally occur. While we will make every reasonable effort to accommodate late arrivals, **arriving late may require shortening or rescheduling your appointment** in order to remain on schedule for other patients.

CANCELLATION & MISSED APPOINTMENT POLICY

We kindly request at least **24 hours or one full business day's notice** (whichever is greater) if you need **to cancel or reschedule** an appointment. Providing advance notice allows us the opportunity to offer your reserved appointment time to another patient awaiting care. We understand that illness, emergencies, and unexpected situations occur and will always take those circumstances into consideration. However, **repeated missed appointments or cancellations with insufficient notice** may result in a **missed appointment fee of $50 or more**, depending on the amount of time reserved.

Appointments lasting **more than two hours** or involving treatment **exceeding $2,000** may require a **deposit of 20%–50%** to reserve the appointment time. Deposits are applied toward the total cost of treatment. **Missed appointments or cancellations without the required notice may result in forfeiture of all or part of the deposit**, except where prohibited by law.

If circumstances beyond our control—including severe weather, illness, equipment failure, or other emergencies—require us to reschedule your appointment, we will provide as much advance notice as reasonably possible.

FINANCIAL RESPONSIBILITY

Payment is due at the time services are provided unless prior financial arrangements have been approved. Emergency treatment or treatment performed without prior financial arrangements must be paid for at the time of service. As a courtesy, Lakeside Dental will gladly submit insurance claims and assist in verifying your insurance benefits whenever possible. Benefit estimates are provided solely as a courtesy and are not guarantees of payment.

While we make every effort to provide accurate treatment estimates and insurance projections, **insurance companies do not always provide us with complete or accurate information**. Insurance policies vary significantly and may contain limitations, exclusions, waiting periods, annual maximums, deductibles, downgrades, coordination of benefits, or other provisions. **Insurance carriers may also reduce or deny payment for completed treatment for reasons not previously disclosed to our office**. As a result, estimated patient portions may change. **Patients are ultimately responsible for all fees associated with their treatment regardless of insurance coverage or payment**.

Patient responsibility may include, but is not limited to:

- Deductibles
- Copayments
- Coinsurance
- Annual maximums
- Non-covered services
- Downgraded procedures
- Services denied by insurance

While we are happy to assist with benefit verification and claim submission, patients remain responsible for understanding their insurance coverage, deductibles, annual maximums, exclusions, and claim status.

Patients are responsible for notifying Lakeside Dental of any changes to their insurance coverage before treatment is provided. Balances remaining unpaid for more than 60 days may be subject to a finance charge of 1.5% per month (18% annually) unless prior payment arrangements have been approved.

Where permitted by law, delinquent accounts may also incur statement fees, returned payment fees, collection costs, reasonable attorney's fees, court costs, and other expenses associated with collection of the account.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of my dental insurance benefits directly to Lakeside Dental for services provided to me or my dependents. I authorize Lakeside Dental to submit insurance claims on my behalf and to release to my insurance carrier, its

representatives, or other third-party payers any information necessary to determine benefits, process claims, or obtain payment for services rendered.

I understand that:

- Assignment of benefits does not guarantee payment by my insurance company.
- I remain financially responsible for all charges not paid by my insurance carrier.
- If my insurance company issues payment directly to me for services provided by Lakeside Dental, I agree to promptly remit those funds to the practice if a balance remains outstanding.

RETURNED OR REVERSED PAYMENTS

Any returned check, declined credit or debit card transaction, chargeback, ACH return, or other reversed payment may be subject to applicable fees and immediate repayment of the outstanding balance.

COMMUNICATION AUTHORIZATION

By signing below, I authorize Lakeside Dental to contact me by telephone, voicemail, text message, email, postal mail, or other electronic communication regarding:

- Appointment reminders ● Missed appointments ● Follow-up care ● Treatment recommendations
- Preventive care reminders ● Insurance matters ● Billing and payment information
- Other healthcare-related communications

I also authorize Lakeside Dental to release the minimum necessary treatment and financial information to insurance companies, third-party payers, financing companies, or collection agencies as necessary for payment, claims processing, or healthcare operations, as permitted by applicable law.

PATIENT AGREEMENT

By signing below, I acknowledge and agree that:

- I have read and understand this Financial Policy and Appointment Agreement.
- I have had the opportunity to ask questions and have received satisfactory answers.
- I understand that I am ultimately responsible for payment of all charges incurred for dental treatment provided to me or my dependent(s), regardless of insurance coverage.
- I authorize the Assignment of Insurance Benefits described above.
- I agree to notify Lakeside Dental of any changes to my contact information, medical history, or insurance coverage.
- I agree to comply with the policies described in this Agreement.

PATIENT INFORMATION

Patient Name (Print): _____

If the patient is a minor or lacks legal capacity:

Parent, Legal Guardian, or Personal Representative:_____

Relationship to Patient:_____

SIGNATURES

Patient / Parent / Legal Guardian / Personal Representative Signature: _____

Printed Name: _____ Date: _____

Witness (Optional) Signature: _____

Printed Name: _____ Date: _____