COCKEYSVILLE DENTAL

Dr. Jocelyn Y. Shin & Dr. Vernon F. Ottenritter Jr.
106 Old Padonia Road. Cockeysville, Maryland 21030
Tel: (410) 628-0118 | Fax: (410) 628-0357

Thank you for selecting us as your family dentist. We are committed to making your treatment a positive experience. As part of our service, we will do our best to contain the rising cost of healthcare.

Appointments:
We request that you keep scheduled appointments that have been reserved for you at your request. We reserve the right to charge you for broken appointment or an appointment that is cancelled with less than 24 hours notice.

Payment:
Payment is due at the time of service. We offer payment options for your convenience. Payment options include: Cash, Check, Credit Cards (Visa, Master Card, Discover). There is a $35.00 charge for any returned checks. A finance charge of 1.5% will be added to accounts with a balance after 30 days. Accounts that are past due more than 60 days will be sent to collections and administrative fee will be assessed to the same account.

Insurance:
We accept assignment of insurance benefits, as a courtesy to you. ***Your dental policy is a contract between you and your insurance company, therefore, you are expected to notify us of any changes in your dental coverage.*** If your insurance company has not paid for your visit within **60 days**, the balance is your responsibility. The balance will be transferred to your account.

Major Services:
Payment is due at the time of service. However, in the case of more complicated treatment, 50% is due at the initial preparation appointment and the remainder is due at the time of insertion. If necessary, we will work with you to arrange a payment option that is mutually agreeable for up to six months.

Usual & Customary
Some services may not be covered by your insurance. This is determined and based on the contract that your employer establishes with the insurance company. You are responsible for any balance left unpaid by your insurance company.

Signed_____ **Date**_____
(read and agreed to by: patient, parent or guardian)

Email address:_____