

**Jeffrey C. Hambleton, DDS, MS**  
**Practice Limited to Periodontics • Dental Implants**  
4505 West 6th Street, Suite B, Lawrence, KS 66049

### **FINANCIAL AGREEMENT**

The following guidelines have been established for payment of financial obligations for services rendered in our office. Please read carefully and select the payment options most suitable for your situation.

- \_\_\_\_\_ **Check/Cash**
- \_\_\_\_\_ **Credit Card** - Visa/MasterCard
- \_\_\_\_\_ **Payment Plan** - To be discussed with Office Manager.

If you have dental insurance, please advise our Receptionist or Office Manager at your initial appointment. As a service to you, we will fill out your dental claims and/or predetermine your dental benefits. We will do our utmost to assist you in obtaining benefits allowable under your insurance plan. However, you should be aware that **your dental insurance is an agreement between yourself and your carrier.** We are not responsible for any limitations imposed by your insurance carrier. A 1.5% finance charge or minimum of \$8.00 will be applied to account balances aged more than 30 days. Returned checks are subject to a \$35.00 returned check fee in addition to any bank fees incurred.

I have selected a payment option and understand my financial obligation with this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **CANCELLATION & "NO SHOW" POLICY**

The following are our policies regarding cancellations and "No Shows". We take this subject seriously as it can make the difference between whether you succeed in your treatment or not.

- **We require 48-hours notice in the event of cancellation.** It is your responsibility, when you call in, to have alternative times in mind that will ensure you get the prescribed treatment.
- **There is a \$40 charge** for a "No Show" or a cancellation without 48-hours notice with our hygienist for a periodontal maintenance appointment.
- **There is a 25% charge of the total of the appointment** for a "No Show" or cancellation without 48-hours notice for any procedure scheduled with Dr. Hambleton or the hygienist at our office.

When a patient does not show for an appointment, three people are affected: the patient him/herself because they do not receive the treatment as prescribed; the dentist or hygienist who now has a space in their schedule since the time was reserved for that patient; and another patient who could have been scheduled for treatment if there had been adequate notice. We will provide a courtesy call to you in advance as a reminder for your appointments, but keeping scheduled appointments at this office are ultimately the responsibility of the patient.

I have read and understand the Cancellation & "No Show" Policy of this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**SIGNATURE ON FILE**

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my insurance carriers.
- I authorize my dentist to act as my agent in helping me obtain payment from my insurance carriers.
- I permit a copy of this authorization to be used in place of the original.
- I authorize payment directly to my dentist.\*
- I understand that I am responsible for my bill.

Name \_\_\_\_\_  
Please Print

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*This is applicable to individuals who have **Delta Dental/Delta USA** as their dental insurance carriers. Benefits from all other dental insurance carriers will be sent directly to the insured.