Bishop Family Dentistry Office Policy

Welcome to our practice, we are pleased to have met you and are excited to assist you and your family with your oral health care. Bishop Family Dentistry is a team of professional smile makers dedicated to leading the community to optimal health. Please take a moment to review our office policies. Feel free to ask any questions you may have. We hope you enjoy your visit and look forward to seeing you in the future.

Sincerely,

Dr. Bryan Bishop

General Office Hours:

Monday-Thursday 8:00am- 5:00 pm (closed for lunch from 12:00- 1:00)

Scheduling/Failed Appointments

In continuing our commitment to you and your oral health we are pleased to reserve appointment times that are convenient for you and your family's schedule. In order to provide all patients with times that are convenient for their schedules and to effectively run our dental office, we must maintain those reserved scheduled times. We will be happy to assist you with rescheduling appointments with at least 48 hour notice of change or cancellation.

If you are not able to make it to your appointment at the scheduled time, please contact our office as soon as possible to determine if we can still see you or if we have another time that day that would work better for you. We want to give everyone the same amount of time for their dental care by meeting their scheduled appointment time.

Appointments are reserved exclusively for you. If you must cancel the day of your appointment or do not show for 2 or more scheduled appointments, we will place you on a short call list to be called for same day appointments only or we will ask that you seek dental care in another dental office. If you are released from our office we will be happy to assist you with your dental records.

We do understand things come up, schedules change and illnesses happen and we will handle each case of missed appointments on an individual basis. We do however reserve the right to charge for missed appointments ($50) or require a deposit to schedule future appointments.

Thank you for your efforts on maintaining your reserved dental time, we hope in return this will allow us to schedule your appointments at times that are convenient for you and your family. Please give 48 hour notice to cancel or change any appointments. _____**Initial**

Appointment Reminders

We are happy to offer a couple of options to confirm your dental appointments. We are excited to offer text message and email reminders. Those reminders begin going out 1 week prior to your appointment. We will also confirm your appointments 1 day prior to with the exception of weekends and holiday, you will be reminded the business day prior to your appointment.

Financial Policy

Commercial Insurance

We will gladly accept and file any insurance plan. Insurance benefits are determined by the insurance company and the employer. Please refer to your benefits policy for explanations on copays and deductibles and for excluded treatment. As a courtesy to our patients we will file your insurance for you for the treatment provided. _____**Initial**

Co-Pays

We ask that you pay all co-pays in office the day of your treatment. We except Cash, Check, Visa, Mastercard, Discover and Care Credit for those payments. Co-pays are only an estimate of the difference between your total treatment and what the insurance company will cover for you. We try to maintain accurate records of those co-pays however since they are only an estimate there may be a balance due after insurance payment. In the event your account becomes past due and must be placed for collection you will be responsible for collection fees and other expenses. _____**Initial**

ArKids/Medicaid Insurance

We are providers for ArKids/Medicaid insurance. Please provide your identification card and a picture identification card. We will verify all Medicaid insurance the day of appointment. The verification must show the patient as active the day of your appointment in order for us to treat you. If for any reason Medicaid does not cover the expenses occurred for the visit you will be responsible for payment of those services provided. **If there is a missed appointment we will notify the state. _____Initial**

Date: _____

Patient Name: _____

Patient/Guardian Signature: _____