2445 MEMORIAL BLVD., SUITE E • MURFREESBORO, TN 37129 • PHONE: 615.809.2742 • FAX: 615.396.8022
WWW.LEECHFAMILYDENTISTRY.COM

Patient Agreement

Thank you for choosing Jeff Leech Family Dentistry as your dental care provider. We are committed to providing you the highest quality dental care available. The following is a statement of our Patient Agreement, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Registration and Medical History form before seeing the doctor.

Payment is due at the time services are rendered. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express for your convenience. We also offer convenient interest-free payment plans. Please ask us for details.

Minor Patients

Please understand that payment of your bill is considered part of your treatment. The parent, guardian or adult accompanying a minor is responsible for payment in full at the time of treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved form of payment prior to the time of services.

Credit Agreement

In consideration of the extension of credit to me, I agree to pay attorney's fees and any other expenses incurred in the collection of my account, should I fail to pay as hereby promised.

Regarding Insurance

We will gladly file your insurance as a courtesy to you. We accept assignment from all insurance companies. Most insurance companies will pay directly to us. If we are able to verify current insurance coverage and predetermine the benefits payable for your treatment, you will only be required to pay the estimated co-payment portion at the time of service. All co-pays and deductibles will be due at the time of service unless a financial arrangement has been made with our Office Manager. We will make every effort to accurately estimate co-pays. Please understand that verification of insurance is not a guarantee of payment. Once all insurance claims have been paid, you will be responsible for any unpaid balance regardless of the level of coverage. Some insurance companies will only send insurance payments directly to you. We will be glad to submit the necessary forms on your behalf. However, in these instances, you must pay the entire balance at the time of treatment. You will then be reimbursed directly by your insurance company.

Broken Appointments

An appointment is a time reserved for a patient with Dr. Leech and his team to provide dental care. Please allow at least 24 hours advanced notice when cancelling or rescheduling an appointment. Any appointment that is cancelled or rescheduled with less than a 24 hour notice will be considered a broken appointment. An office visit fee may be imposed for a broken appointment. Repeated broken appointments may result in dismissal from our office.

Thank you for taking the time to read and understand our Patient Agreement. Please let us know if you have any questions or concerns. We are committed to providing you with a positive dental experience.

X____ Date__________________________

Signature of Patient or Responsible Party