Magrath Dental Office Policies

Welcome to Magrath Dental. We would like to take this opportunity to welcome you to our practice and thank you for choosing our office to provide dental care for you and/or your family. We value our relationships with our patients and strive to provide quality care for everyone.

Payment

Unless prior arrangements have been made, payment is due for all treatment completed on the day the service is rendered. We accept MasterCard, Visa, Interac/debit and cash. If there are any outstanding charges on your account, payment is expected in full prior to your next appointment. If full payment is not made, your appointment will be rescheduled until your account is paid.

Dental Insurance

Magrath Dental is an assignment office, which means that our dental office files the primary and secondary benefit claims on behalf of our patients and request that the benefit company pays our office directly for your services. As a courtesy, our staff will complete the dental portion of the benefits claim form to submit to your benefit provider. To expedite the processing, please ensure you provide our office with accurate information and note any changes in benefit coverage, address and phone numbers.

If your policy does not allow payment directly to our office you are then responsible for payment of the full amount, at the time of your appointment. We will still submit the claims on your behalf and have the benefit provider reimburse you directly.

Please be advised that dental benefits are a contract between you, your employer, and your benefit provider. Under the Privacy Act, your benefit will not and are not obligated to provide our office with any details regarding your coverage. We cannot influence how much of our fees your benefits will cover. Your benefits are determined by your individual policy and carrier. It is a contract negotiated between your employer and the benefit provider. It is your responsibility to know the parameters of your benefits, such as annual maximums, frequencies, renewal dates, and any other limitations. Receiving our services indicates your acceptance of responsibility to pay the balance due. Our objective as dental health professionals is to diagnose any treatment required according to each patient's particular needs. We do not know if your benefits will cover the treatment we diagnose, as this is only outlined in your policy handbook. You will be responsible for fees incurred and balances not covered by your benefit provider.

If, after 90 days, your dental benefit provider has not responded with payment you are personally required to provide full payment of your account. Please understand that by this point we will have reviewed and contacted your benefit company at least 3 times.

Magrath Dental

Quality Care With A Personal Touch

If you require a "predetermination" we will provide a treatment plan for review by the benefit provider. However, please remember that the financial obligation for treatment is between you - and this office. The benefit provider is responsible to you and not this office. Please be advised that a response from your benefit provider may take four to six weeks to obtain. Often these responses will be communicated directly to you and not our office.

lf you do not have any benefits, we do require payment in full, at the time of your appointment.

Late or Missed Appointments

Our office will notify you of your upcoming appointment via email, text or telephone. We ask that you respond to our contact to ensure we know you will be in attendance at your appointment. We require a minimum of two business days notice should you need to reschedule or cancel your appointment. Your appointment is valuable time that the doctor as reserved specifically for you. In any case where insufficient notice is given a $100 missed appointment fee may be charged to you, or we may require you to prepay to reserve your next appointment.

We look forward to providing you with quality dental care. If you have any questions or concerns, please feel free to ask any of our staff.

Sincerely,

Dr. Herbert Woo & Associates

I accept and understand the above policies and agree to abide by them.

Patient/Legal Guardian Signature:_____

Date:_____

Patient Name:_____