VAN DENTISTRY
TAN H. VAN, DDS, P.A.

22038 W 66th Street
Shawnee, KS 66226
O: 913-441-9553
F: 913-441-9559
P: 816-519-9446

816 NW Vesper Street
Blue Springs, MO 64015
O: 816-224-7933
F: 816-224-1957
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OFFICE POLICIES

Appointments:

1. Appointments are scheduled in advance so that enough time can be reserved to provide you with the proper treatment. We ask that you give a **24 hour notice** when you are unable to keep your scheduled appointment. This allows us to offer that time to another patient who may need treatment also.
2. Repeated broken appointments or cancellations with less than a 24 hour notice **may result in dismissal of the patient from the practice.**
3. We try to confirm appointments by phone at least 24 hours in advance; however, it is ultimately the patient's responsibility to remember their appointment dates and times.

Fees:

Our office operates on a fee for services basis. All co-pays are due at the time of service. We will file all insurance claims. If we are not contracted with your insurance company, all charges including examination, consultation, x-rays and special tests performed in the office are due and payable in full immediately after you receive your statement. We accept cash, money orders, MasterCard, Visa and Discover. If other arrangements are necessary, please discuss them with our office manager **before** you see the dentist. Full payment is expected within 30 days. Any statement not receiving a payment after 30 days is past due.

Payment of the dentist's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charged is covered, in whole or in part, by insurance. It is your responsibility to know what is and is not covered by your insurance company. It is your responsibility to know your dental plan.

I understand that regardless of performance by my insurance company, I am responsible for payment of my account. In the event that I should default or may account should become seriously delinquent, I agree to pay all reasonable collection costs including but not limited to attorney fees, agency fees, court costs and the like.

I, _____, have read and understand the abovementioned office policies.
Patient's Name (Printed)

Signature: _____ Date: _____

Authorization for Release of Dental Records

I authorize the release of any dental or other information to my insurance company as they request. I agree that a photographic copy of the authorization is as valid as the original.

Signature: _____ Date: _____

Authorization to Pay Benefits to Dental Provider

I authorize payment of medical benefits directly to Tan H. Van, DDS, P.A. (Dr. Tan H. Van) for services rendered.

Signature: _____ Date: _____