JOSEPH A. SAVOINI, D.M.D.
FAMILY DENTISTRY

OUR OFFICE POLICY

Dr. Savoini and his team would like to welcome you to our office. Our practice exists solely for the care of our patients' oral health. Dr. Savoini's goal is to provide you with the finest dentistry available. Our team's enthusiasm and involvement as well as your cooperation contribute greatly to the achievement of this goal.

Payment is due when treatment is rendered. As a courtesy to you we will file your insurance claim. You will need to pay your estimated share at the time of service. We try our hardest to help you with your dental benefits. Learn your policy so you can understand your coverage. Your insurance company may pay all, some or none of the insurance co-payment estimate. We are not responsible for what benefits your insurance pays. Ultimately, this account is your responsibility regardless of what insurance pays.

We are a thriving practice and to make our schedule run as smoothly as possible we reserve individual time for each patient. If you are unable to honor the appointment time that you reserved, a full business day of our office is required. Thus, if Monday is your reserved time, please call us Thursday. If an appointment is failed and no prior notice is given there will be a charge for the appointment according to how much time was reserved. Repeated failures will incur a pre-pay requirement at the time of scheduling. Pre-paid amounts for failed appointments will not be refunded.

Our office hours are Monday thru Thursday from 8:00am to 5:00pm, closed for lunch from 12:00pm and 1:00pm. If you have an emergency after office hours, please leave your name, number and a message on our answering machine as phones are monitored throughout the weekend.

We are looking forward to getting to know you and your loved ones. Thank you for choosing Dr. Savoini and his team to support your dental health.

I hereby certify that I have read and abide by this agreement, and that I grant permission to Dr. Savoini and his team to render treatment.

Patient/Responsible Party _____Date_____

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