Office Policies

Carl F. Lipe, DDS
6825 E. Hampden Ave. Ste. 200
Denver, CO 80224
303-744-0600

- We try our best to stay on schedule to minimize your waiting. Due to the fact that Dr. Lipe provides many types of dental services, various circumstances may lengthen the time allocated for a procedure. Emergency cases can also arise and cause delay. We appreciate your understanding and patience. If this causes problems with your schedule, we are happy to reschedule for a time that is more convenient.

- If you find that you are unable to keep your appointment, we request that you give a minimum of **24 HOURS NOTICE.** Otherwise, we reserve the right to apply a charge to your account of $150 per scheduled hour. This policy helps us keep our operating costs as low as possible for all of our patients.

- Unless you have a dental emergency, your first appointment will be for a complete exam and full mouth x-rays. We will provide you with a summary complete with your estimated cost of treatment that is diagnosed and recommended by Dr. Lipe. All emergencies are to be paid in full at the time of service, if insurance is present a copay will need to be paid, no exceptions. Fees for treatment are to be paid at the end of each appointment. For your convenience, we accept Visa, Master-card, Discover and Care Credit. We do not offer in office financing.

- As a courtesy to you, we will bill your dental insurance provider. However, we do expect for you to pay your **ESTIMATED** portion (copay) at the time of the service. Please be aware that you are fully responsible for the charges that are **NOT COVERED** by your plan. It is also understood that if your insurance claim remains unpaid for sixty (60) days from the day treatment began, the claim will be turned over to you for payment in full. Please keep us informed of any changes to your insurance plan at least 24 hours before your scheduled appointment.

- In the event of default on your account, you may be referred to a collection agency. Should that occur, you will be required to pay all costs of collections. A $25 fee will be charged for returned checks.

I have read, understood and agree to these policies.

Print Name: _____

Signature: _____ **Date:** _____