smilesinc
Dentistry & Maxillofacial Surgery

"Welcome to our office!" *Thank you for choosing Smiles Inc. Our team is committed to providing you with the best possible care in a comfortable and professional manner. It is important that you are aware of a few office policies so that our relationship remains a positive one. Please read the following information carefully, and ask any questions that you may have.*

1. **REGISTRATION:** You will be asked to complete a Medical History form at your initial visit. Please inform the staff of any changes in your medical history, and any additional medications you may take, or changes in personal information.
2. **DIRECTIONS**: We are located at 12, Dundonald Street West in Hamilton, in the former Olympic Club gym building. Dundonald Street runs in front of Masters Ltd. Our website has a google map.
3. **PARKING**: There are a few parking spaces available on Dundonald Street for one hour, (there is always bike parking available). However, we do not guarantee they will be available so please give yourself enough time to get here and park. Bulls Head carpark always has spaces.
4. **E-MAIL REMINDERS**: We use Smile Reminder System as a way of confirming appointments, please press the ***Green*** button on this email to confirm. A call will be made if no email is available. We do ask that appointments are confirmed 24 hours in advance. Late cancellations (less than 24 hours) or a missed appointment fee of $100 will be charged.
5. **APPOINTMENTS:** We schedule our appointments to be as efficient as possible. Please try to be on time for your scheduled appointment. If you are late, it may be necessary to reschedule that appointment to another time and you will be charged the late cancellation fee.
6. **TO CHANGE AN APPOINTMENT**: If you need to change an appointment, please do so with as much notice as possible, ideally at least 48 hours in advance.
7. **PAYMENTS**: The patient portion (co-pay) is collected at the time of service, and the amount due depends on your Insurance benefits. We accept cash, cheques, debit and credit cards, but not American Express. Payment can also be made online to BNTB 20 006 060 266298100 (please place the name of the patient in the beneficiary note section).
8. **CONFIDENTIALITY :** Health regulations stipulates that there should be no photography /videography within a healthcare facility; which includes snapchat, facebook, whattsapp and all other social media.
9. **INSURANCE** : We will assign payment to your insurance company, but any unpaid balance is your responsibility. And any payments received from your insurance should be returned to Smilesinc. All unpaid accounts are sent to Bermuda Credit Association.
10. **NO INSURANCE**: If no insurance details are provided, or you change policy mid treatment you will be FULLY responsible for all treatment balances.
11. **K.E.M.H. APPOINTMENTS**: Where possible, these appointments require *one week* cancellation notice. There is a missed appointment fee for these appointment cancellations without proper notice.

- ***I have read and understand the above office policies, and agree to abide by them.***

Signed: _____ Date:_____

12 Dundonald Street
Hamilton HM 09
Bermuda

Tel: 296 0990
Fax: 296 0991
Email: smiles@smilesinc.bm
Website: www.smilesinc.bm

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NAME: (FIRST) _____(LAST)_____(MIDDLE)_____

(MAILING ADDRESS): _____

(PARISH): _____ (POSTAL CODE): _____

DATE OF BIRTH): (Day /Month/Year) _____

CONTACT INFORMATION:

(HOME) _____ (WORK) _____(CELL)_____

(EMAIL) _____

EMERGENCY CONTACT PERSON:

(NAME): _____ (RELATIONSHIP) :_____

(HOME PHONE): _____ (CELL/WORK): _____

NAME OF EMPLOYER: _____

DENTAL INSURANCE? YES or NO IF YES, PLEASE CIRCLE ONE: ARGUS BFM COLONIAL

IF NO DENTAL INSURANCE – I AM FULLY RESPONSIBLE FOR ANY TREATMENT BALANCE : _____ Signature

FINANCIAL AGREEMENT:

I, the undersigned, certify that I (or my dependent) have insurance benefits with my insurance company, and when warranted, assign directly to Smiles Inc. I understand that I am financially responsible for all charges not paid by insurance, and that all unpaid accounts are sent to Bermuda Credit Association. I hereby authorize Smiles Inc. to release all information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions.

(SIGNATURE) _____ (DATE) _____

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