Dean J. Kokinias, D.D.S.

WELCOME

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We look forward to seeing you on a regular basis. We continue to grow with your recommendations.

OFFICE HOURS Our standard hours are Monday through Friday 8:00 a.m. – 5:00p.m.
Alternating Saturdays 8:00 a.m. – 1:00 p.m., closed Wednesday.

CANCELLATION AND NO SHOW POLICY

Office hours are by appointment and we do value your time. Appointment time is reserved for you alone. When you make an appointment, please be sure that you will be able to keep it.

Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a minimum charge of $50 for a broken appointment or cancellation with less than 24 hours' notice for your appointment.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

PAYMENT

Payment for treatment is required at the time of service. As a courtesy to you, we will file to your insurance based upon the information you provide us. This is not a guarantee of payment. Your insurance is your financial responsibility. Our copay calculation is an *estimate* of your insurance benefits, you (the patient) are responsible for the total cost of your treatment and services. In the event your account becomes past due and is turned over to collection, you will be responsible for all cost of collections, including collection agency fees, attorney fees and court costs not to exceed 50%.
Financing is available through CareCredit. Please ask our receptionist for more information.

PATIENT COMMUNICATION

We may call your home, cell or other designated location and leave a message on voice mail or with any person who answers, send emails or text messages regarding any items that assist the practice in carrying out treatment, payment and other operations, such as appointment reminders, insurance items and any call pertaining to your dental care, including treatment planning.

I understand the policies of this office.

_____ _____ _____

Patient Signature (parent if minor) Print Name Date

Staff _____