POLICIES REGARDING TREATMENT

APPOINTMENTS
Appointment times are “reserved”. This means that we do not “doublebook” our appointments. This is an advantage to you because it allows you to be seen at a specific time. We respect your time and we make a special effort to be on time.

CANCELLATION AND BROKEN APPOINTMENTS
24 –Hour notice is required when canceling or rescheduling an appt. If an appointment is cancelled with less than 24-hours notice, a $50 fee will be applied to your account if insufficient notice is given.
Failure to show for an appt does not release the obligation for the time. We are very understanding of unusual circumstances; however chronic failure of appointments is not compatible with our type of practice where the times are reserved.

Initials:_____

CONFIRMATION OF APPOINTMENTS
We will make every effort to reach our patients to “remind” them of their appointments at least 24 to 48 hours in advance. Failure to reach an individual does not remove the financial obligation for the time. Scheduled appointments are the patient’s responsibility. If your appointment is not confirmed directly with our office it will be given to another patient.

Initials:_____

INSURANCE
Please be aware that the patient is responsible for the entire fee for the procedure when services are rendered. If you have insurance we will gladly process your claim, some companies pay fixed allowances for certain procedure and other pay a percentage of the charge.
In the case where insurance will pay an estimated portion the insurance company will distribute a check to the patient and not the office.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY THE ENTIRE AMOUNT AT THE TIME OF SERVICE AS WELL AS ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE COMPANY.

Initials:_____

There will be a $25.00 fee for all returned checks.

I hereby certify that I have read the above and agree with all the terms and conditions.
This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist of the insurance benefits otherwise pay

Patient/Guardian Signature:_____Date:___/___/___