OFFICE POLICIES

Patient name _____

FINANCIAL POLICY

Patients are expected to pay by cash, check, or credit card on the day services are rendered. For patients with dental insurance, we will accept assignment of benefits. Most dental insurance plans do not cover 100% of treatment costs. Because of this, and the delay in receiving payment from the insurance company, you are responsible for paying your deductible and co-payment on the day services are rendered. We will estimate this amount as closely as possible using the insurance information available to us; however, this is an estimate. Our agreement is with you, not your insurance company. We will assist you in working with your insurance company, but ultimate responsibility for payment lies with you. Any balance remaining after sixty (60) days is due in full. I understand that a finance charge of 1.5% will be added to my account for charges due over sixty (60) days.

Signature _____ Date _____

LATE OR MISSED APPOINTMENTS

We know your time is valuable, and we reserve a time specifically for you so we can provide the best service possible. To help us maintain this level of service, please give us at least 24 hours' notice if you cannot keep your appointment. This allows us to offer the time to patients with an urgent need. Patients may be subject to a $75 fee for missed appointments and appointments cancelled with less than 24 hours' notice. Prescheduled treatment appointments cancelled outside these guidelines may have a higher fee, depending on the type of service scheduled.

Signature _____ Date _____

CONSENT & AUTHORIZATION

MINOR / CHILD CONSENT

I, the parent or legal guardian of:

Patient name _____

request and authorize the dental team to perform necessary dental services for my child, including but not limited to X-rays and the administration of anesthesia deemed advisable by the doctor, whether or not I am present at the appointment when treatment is rendered. I agree to be responsible for payment for all such services.

Responsible party signature _____ Date _____

AUTHORIZATION

Please read the following statements and sign below.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company, if applicable, to pay the dentist or dental group the insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions, if applicable.

I authorize the dentist to release all information necessary to secure payment of benefits.

Signature _____ Date _____