



Office Policies

Dental Appointments ☐ Initials: _____

Our goal is to provide quality care to all of our patients. When an appointment is scheduled, a reserved block of Doctor's time has been provided for you and/or your family. We understand your time is valuable and so are your commitments. Please schedule accordingly. A reservation fee WILL be collected at the time of scheduling.

We reserve the right to charge a **\$50.00 fee per HR** for any missed or rescheduled dental appointments that have not been cancelled/ rescheduled **48 hours** prior to the scheduled time.

We reserve the right to charge a **\$100.00 fee per HR** for any Specialty Appointments missed or rescheduled dental appointments that have not been cancelled or rescheduled **72 hours** prior to the scheduled time.

Due to high demand of our Saturday appointments, limited spacing is available and a **72 hour** notice is required for any cancelled or rescheduled appointments. A **\$100.00 fee per HR** will be applied. Once a Saturday appointment is missed, another Saturday will not be appointed.

Confirmation/ Late Appointments ☐ Initials: _____

All patients that arrive more than **15 minutes** late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made. Please call the office to make accommodations. **ALL appointments must be confirmed. Failure to do so will result in the appointment being CANCELLED.**

Financial Responsibility ☐ Initials: _____

Your signature on this form acknowledges that you, the patient, parent, or legal guardian, agree to bear full financial responsibility for all services provided if;

1. You are determined not to be eligible for insurance coverage.
2. The services are not a covered benefit under your plan.
3. There is a patient portion determined by your insurance plan that is payable at the time of scheduling your reserved appointment.
4. We **DO NOT** guarantee what insurance will cover. We can only provide an **estimate**.
5. Unpaid past due balances(over 30 days) will be subject to 5% interest charges.

I understand that the **DENTAL OFFICE** has no control over insurance payments/coverage and can only estimate or explain my insurance coverage to me. If I fail to pay for the treatment rendered after insurance benefits are paid I understand the dental office will submit the debt to small claims court and any court costs and late interest penalties will increase the balance due.

Please keep in mind, any financial estimates presented to you for dental treatment, is only an **ESTIMATE** of what your insurance company will pay. We cannot guarantee what insurance will pay. ****Financing options are available****

Co-Payments/ Reservation Fee ☐ Initials: _____

We will collect either the entire copayment or a portion to reserve an appointment for treatment with the dentist or hygienist. If the appointment is missed or failed to meet the office policy, the cancellation fee **WILL** be deducted from the Reservation Fee.

Returned Checks ☐ Initials: _____

A fee of **\$35.00** will apply for any checks returned to us for any reason. Future services will require payment by debit/credit card.

Print Name: _____

Signature: _____ Date: _____