OFFICE POLICY

Patient/Family Name: _____

It is our policy to discuss our fees in advance of performing any treatment in this office. Your fee is based upon an estimate derived from a complete and thorough exam. If additional treatment is needed the estimate may change. All estimates are valid for six months. You must pay in full at time of the visit. We will submit to your insurance for their estimated portion. If for any reason they do not pay or pay less than expected, the insurance balance becomes your responsibility. If any collection fees, court costs, and attorney fees are incurred to enforce payment required by this agreement they will be paid by the responsible party. We accept payments in the form of cash, money order, credit card, and check. There will be a $25.00 NSF fee for any checks returned to our office.

Once an appointment is made, please remember that this time has been specifically scheduled for you. Please arrive on time for your appointments, and if you need to change your appointment we ask for a 48hr notice. There will be a $25.00 fee for all missed or cancelled appointments without adequate notice. The office reserves the right to dismiss a patient for canceling an appointment without adequate notice or for missing an appointment at any time.

I agree to be responsible for the cost of all procedures performed I this office, including any treatment not a benefit of any dental insurance I have. I certify that I have read, understand, and agree to the terms of this policy. I have also received a copy of this policy, if requested.

_____ _____

Responsible Party Date

_____ _____

Witness Date