OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.**
- For patients with Dental Insurance, please keep in mind that your insurance plan is not designed to pay all charges, but simply provides some assistance to you.
- Prior to your visit we collect your insurance information so that we can obtain a basic breakdown of your dental benefits. It is your responsibility to understand your insurance coverage. We will provide you with the best possible estimate for your treatment.
- Please note for your convenience, we do accept VISA, MasterCard, Discover, AMEX and Care Credit as well as checks and cash. (Care Credit allows you to make monthly payments interest free)

  We will file your dental insurance claims for you at no charge; however, we ask that your deductibles and your estimated portions be paid as services are rendered. Any and all account balances are ultimately your responsibility.

OFFICE POLICIES

- We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments**. If you must change or miss an appointment, we would appreciate a 48-hour notice. We reserve the right to charge for broken and no show appointments. Repeated cancellations or failures could result in a broken appointment charge or no reappointment.**
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. **A monthly billing charge will be assessed for any account balances over 30 days and may be subject to interest or late payment fees. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.**
- **For checks returned to us as unpaid by your bank, we will charge a $35.00 fee. This fee will be in addition to the amount on the check. Any future payments will need to be paid by credit card or cash.**

CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date ___________ Signature _________________________________ (Patient, Parent or Guardian)