Office Policies

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy and consent for treatment.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service. I understand there is a $35 processing charge for non-sufficient funds or returned checks. Any charge which is unpaid shall be subject to a monthly interest charge of two percent (2%) and should my account be assigned for collections, I agree to be responsible for all costs and attorney's fees of thirty-three and one third percent (33 and 1/3rd%) of all monies due.

I grant permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, I agree to pay the full remaining balance.

I understand this office will always do the best to help maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated to pay this office in accordance with its credit terms and policy.

I authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. I consent to the use of these by the doctor for scientific papers or demonstrations. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance, as necessary. I agree to the use of anesthetics, sedatives, or other medications as necessary, and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications.

I understand that if I miss or cancel an appointment with less than 24-hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date_____

Patient Name

_____

Patient/Parent/Guardian Signature (Responsible Party)