

Please read carefully and sign at each place requested. Thank you for choosing our office as your dental healthcare provider. We are committed to your successful treatment and the retention of your natural teeth for your entire life.

**CHANGES IN MEDICAL HEALTH**

I am aware that it is my responsibility to inform this office of any changes in my medical or health history

**FINANCIAL POLICY**

Full payment is due at the time of service. We accept cash, checks, all credit cards, and participate with other third party financing like Care Credit and Citi Card. Our dental practice is committed to providing the best treatment for our patients and our fees are usual and customary for our area. The patient or responsible party agrees to make payment regardless of any insurance company's arbitrary determination of usual and customary fees.

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**ADULT PATIENTS**

Adults are responsible for full payment at the time of service.

**MINOR PATIENTS**

The adult accompanying a minor and the parents, or guardian of minor, are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized with the parent or guardian.

**INSURANCE**

We may accept assignment of insurance benefits for dental care, as a courtesy. The balance is the patient's responsibility whether the insurance company pays its portion or not. We cannot bill the insurance company unless we are provided with the correct information. The insurance policy is a contract between the patient and the insurance company. Our office is not a party of that contract. We are always out of network. If the insurance company has not paid the account balance in full within 30 days, the patient will be responsible for the entire balance. Please be aware that some, and perhaps all, of the services provided may be non-covered procedures and/or not considered reasonable and necessary under the dental insurance coverage plan.

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**MISSED APPOINTMENTS**

We regret that we must charge for repeated missed appointments. Since we do not double book, we rely on our pre-scheduled, confirmed patients to utilize the time reserved. Unless cancelled at least 48 hours in advance, cancellations are subject to a \$50.00 charge for a missed appointment. We are lenient in our policy and do not impose this charge until there are repeated offenses.

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\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

Thank you for completing this form. The information provided will help us serve our patient's dental healthcare needs more effectively and efficiently. We will be available and happy to answer any additional questions or patient's concerns.