OFFICE POLICY AND CONSENT FORM

NAME: ____ **DATE:** ___________________

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 treatment involving fees about $500.00, special financial arrangements may be discussed with our office manager.

- For patients with Dental Insurance:

  We will file your claim for you at *no charge*; however, we ask that your deductibles and your Estimated portions (20-100%) be paid as services are rendered. Although we gladly filed dental insurance claims, any and all account balances are ultimately your responsibility.

  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment

- Please note for your convenience, we do accept checks and cash as well as VISA, MasterCard, Discover, American Express, and Care Credit.

OFFICE POLICIES

- Your appointment time is set aside especially for you. 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**. Repeated cancellations may require a pre-paid deposit in order to reschedule, or in some cases no reappointment.

- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible for all fees incurred.**

- We will be fair in working out special finances with you, but please also be fair to us with your commitments. ***A 1.5% finance charge may be assessed monthly on all overdue balances.***

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 sedations, as 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 authorized assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

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Signature (Patient, Parent, or Guardian) Date