

\*\*\*\*\*PAYMENT IS EXPECTED AT THE TIME OF SERVICE\*\*\*\*\*

**\*\*INSURANCE**—It is our office policy to bill your insurance carrier as a courtesy to you although you are responsible for the entire balance if your insurance does not pay. We require that your estimated portion be paid at each visit. **YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE CANNOT GUARANTEE PAYMENT OF YOUR CLAIM BUT WE WILL HELP YOU RECEIVE BENEFITS TO WHICH YOU ARE ENTITLED.**

Please circle one or more of the following methods of payment.

- |  |                      |
|--|----------------------|
| (1) Check (Drivers license required.....All checks verified) | (5) American Express |
| (2) Cash   | (6) Discover         |
| (3) Visa   | (7) Finance Company  |
| (4) Master Card  | (8) Insurance        |

Dear Patient:

For your convenience, we have available all of these payment options. You have a right to expect high quality dentistry and to understand the fees before services are rendered, if you desire. We expect our patients to comply with the payment methods at each visit. With this type of relationship, we can better serve your dental needs. Thank you.

I have reviewed the various payment options and I agree that I am responsible for the total bill and will follow the methods I have circled above.

\_\_\_\_\_  
Patient Signature

### APPOINTMENT POLICY

There are a limited number of appointments available. There is often a waiting list. Because of this, it is vital that you keep your appointment. In order to serve all of our patients better, we are enacting this policy. Please read and sign it, showing that we have your agreement.

1. If you must cancel an appointment, you must notify us at least 24 hours in advance.
2. If you are 10 minutes late (without advance notice) you may lose your appointment slot if someone is here.
3. If you miss an appointment without calling 24 hours in advance, the following will occur:
  - A. First offense = 50% of appointment charges
  - B. Second offense = 100% of appointment charges
  - C. Third offense = Payment in advance before scheduling or treatment on a walk-in basis (INSURANCE PATIENTS WILL PAY OUT OF POCKET)

I, \_\_\_\_\_, have read and agree to comply with this policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_