OFFICE POLICY AND CONSENT FORM

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 REQUIRED AT THE TIME OF YOUR VISIT. For treatment involving fees around $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 your deductibles and your estimated portion be paid as services are rendered. Although we gladly file 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 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. **If you cancel without a 24 hour notice you will be charged a $30.00 late cancellation fee**. 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 patients who requests treatment for a child is responsible to us for all fees incurred.**

All **Oral Sedation** cased must be paid in full to reserve an appointment time due to the long duration of the appointment as well as being pre-medicated prior to your arrival.

If you account becomes delinquent and is sent to collections the collection agency we use has the right to add their cost to your total amount due.

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, 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 the release of dental records to my insurance company.

_____ _____

Signature (Patient, Parent or Guardian) Date