



Debbie-Ann Bailey, D.M.D

Appointments in our office

Here at Dr. Bailey’s office we strive to give our patients the best of care. We give appointments that work best with your schedule as well as ours. We understand that different situations can occur however, we ask our patients to please give us 48 hours notice if unable to keep their appointment. Any patient that has confirmed their appointment and “CANCEL” or “NO SHOW” on the appointment day will be charged a \$50 fee. We appreciate your understanding as we reserve this time for you.

Initial

Financial Policy

In our office we work individually with each patient to suit their needs. We value our patients and our financial coordinator is able to inform you before any treatment is started what the cost will be. Our office does not send statements, and payment is due at the time of service. As a courtesy we will file your insurance.

Initial

If insurance does not pay in 90 days you are responsible for your balance.

Initial

Please Sign Below that you have read and understood this page:



Debbie-Ann Bailey, D.M.D

CONSENT FOR TREATMENT

Patients Name: _____

Date: _____

I have discussed any concerns where I thought necessary, and I am satisfied that I have a full understanding of the proposed treatment and risk involved. I hereby authorize Debbie-Ann Bailey D.M.D and associates to perform the necessary treatment needed. Dr. Debbie-Ann Bailey D.M.D and associates explained to me fully the purpose of the treatment needed. I hereby give my permission for the use of dental records, including photographs taken in the process of examinations, treatments, and retention for the purpose of professional journals. I have also been explained the cost of treatment and the insurance estimated payment if any. *

Patient Signature: _____

Witness Signature: _____

Signature of guardian if patient is minor: _____

*If for any reason your insurance company does not pay the estimated amount, it becomes your obligation.