

FINANCIAL AGREEMENT POLICY

To reduce our administrative costs and keep our fees to you as low as possible, we ask that you pay for all services rendered at the day of your appointment. If you have dental insurance, please pay your **estimated** percentage at the time you receive treatment. Any balance over 60 days will be subject to finance charges at the rate of 1.5% per month. Returned check fee is \$25.00.

Please indicate below the method of payment you intend to use to pay for your dental treatment, including your co-payment.

PAYMENT OPTIONS

_____ Cash or check

_____ Visa or MasterCard

_____ Electronic Funds (Debit Card)

EXTENDED PAYMENT OPTIONS

_____ Care Credit (Approval Required)

APPOINTMENT CANCELATION POLICY

Our goal is to help you achieve and maintain a healthy and attractive smile. In order to accomplish this, it is important that you keep the appointments reserved for you. To better serve our patients we require a 48 hour cancellation policy. If you are unable to give prior notice, a late cancellation fee may be charged to your account.

MISSED APPOINTMENT POLICY

1. For the **FIRST** missed appointment, we will try to assist in rescheduling the appointment at a time which may be least likely missed, forgotten or interrupted.
2. For the **SECOND** missed appointment within 1 year, you will receive a letter from our office stressing the importance of your dental health and the potential health related consequences for delaying dental treatment. Pre payment may be required prior to rescheduling.
3. If a **THIRD** missed appointment should occur within 1 year, our office will not reschedule you for another appointment, unless other arrangements have been made.

Print Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date

Reviewed by