Maria G. Duque, D.D.S. Dental Arts

General Terms of Practice

Knowing that you had a number of options presented to you when deciding upon your dental provider, I'd like to take a moment and thank you for choosing to have your dental care performed by this practice. Rest assured that you have made a wise decision as my staff and I are committed to the success of your dental needs and your overall experience.

As a client of Dr. Maria G. Duque Dental Arts please take a moment to review this document, which highlights the general terms of this practice. Upon review, please sign and date this document as your understanding and acceptance of these terms.

Should you have any questions about any of the below, please feel free to consult with me prior to signing.

Thank you again for choosing us as your dental care provider. We look forward to a long and mutually beneficial relationship.

Sincerely,

Maria G. Duque, D.D.S.

- Patients are required to complete all necessary Registration, Medical and Dental History and Insurance forms prior to receiving treatment.
- Insurance may not cover all of your dental expenses. It is the patient's responsibility to pay any deductible, co-payment or other balance not paid by your insurance company, including any amount exceeding your plan's annual maximum.
- This practice reserves the right to charge a $50.00 cancellation fee to the patient for any missed appointment, unless patient provides the practice with twenty-four (24) hour advance notice.
- This practice reserves the right to charge a $35.00 service fee to the patient for each returned check.
- Payment in full is expected when services are rendered unless prior financial arrangements have been agreed upon, in writing, between the patient and Dr. Maria G. Duque.
- This practice reserves the right to charge a finance charge at the rate of 1.5% per month (18% annual percentage rate) to all outstanding balances not paid within 30 days. Please note that balances over 60 days past due will be forwarded to a collection agency for assistance and the patient will incur an additional charge equivalent to 20% of the balance due for this practice having to utilize this service.

By signing below I acknowledge that I have reviewed, understand and accept the above listed general terms of this practice.

Patient's Signature: ____ **Date:** _________________________