FINANCIAL & CANCELLATION POLICY

FINANCIAL POLICY

I understand I am financially responsible for all services rendered by the dental office. These services must be paid for at the time of treatment. If I have dental insurance, I must pay my *estimated* portion at the time of treatment, and I am totally responsible for anything my insurance company does not pay within 45 days after treatment. I am also responsible for full payment if insurance is terminated.

Patient /Parent or Guardian Signature_____ Date:_____

CANCELLATION POLICY

Your appointment times are reserved exclusively for you. 24 hours notice is appreciated if you are unable to keep your appointment. If you fail to keep an appointment a $50 fee may be charged. You may be placed on a short notice call list. We also reserve the right to no longer offer services.

Patient /Parent or Guardian Signature_____ Date:_____