Financial Agreement

Date

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.

I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all informtion necessary to secure the payment of benefits.

I understand that i am financially responsible for all charges whether or not paid by insurance.

Dental Office Cancellation and No-Show policy:

Please be courteous and call our office promptly if you are unable to attend your appointment, we require that you give us at least 48-hour notice so that we have the opportunity to offer your appointment to another patient.

A "No-Show" is someone who misses an appointment without notice. We have voicemail which is able to receive messages 24-hours a day. No-Shows incovenience patients that are in need of our services. A failure to cancel a scheduled appointment without 48-hour notice will be recorded in the patients file and a cancellation fee of $50.00 will be charged. If you fail to be present for your scheduled appointment you will be charged a "No-Show" fee of $50.00. All fees will be due prior to seeing the doctor at future visits.

Name *

First Name

Last Name

Phone Number *

Email Address *

Signature *