- I understand that I am responsible for payment of all services provided by this office for myself as well as my dependent's. I understand payment is due in full at the time of service. Payments accepted: cash, check and all major credit cards.
- I understand your office offers many other payment options including no-interest, same as cash financing through Care Credit upon approval, Smile Care Savings Plan, and a pre-pay option with a discount. Our Accounts Manager will be happy to go over the details on all of our payment options.
- I understand should my account go into collection, I risk being dismissed as a patient and a collection fee may be charged along with full payment of the balance due, should I desire to become an active patient again. I will then be required to pay in full prior to service as deemed necessary.
- I understand that my insurance coverage is a contract between my employer and the insurance company. Not all services are covered benefits. Some insurance companies arbitrarily select certain procedures they will not cover. As a dental care provider, our relationship is with you and not your insurance company. We file your insurance claim as a courtesy. We must emphasize that we can make no guarantees of estimated coverage or payment.
- I understand my appointment has been reserved for me therefore in the event I need to reschedule I must give a 24-hour notice. Keep in mind this must be during business hours and failure to do so will result in a cancellation fee.
- I understand that it is my responsibility to advise this office of any changes in the information I provide, including but not limited to patient information, health history and dental insurance.
- I understand I must sign a record release request form and that applicable fees may apply for copies of dental records and x-rays.
- I understand an insufficient funds fee will be added to my account should I have a returned check.
- When scheduling extensive appointments of two hours or more a 20% deposit will be required when the appointment is made.

Patient Signature: _____ Date: _____

Parent or Guardian: _____