APPOINTMENT COMMITMENT:

Our goals are to provide you with dental care of the highest quality and to respond promptly to requests for appointments. In most situations, at least an hour of the doctor's time has been set aside to spend with you. In order to meet your needs as well as the needs of other patients we ask for your help and courtesy. If for any reason you are unable to keep your appointment as scheduled, **please notify our office of such at least 24 business hours before your appointment time.** This will allow us proper time to schedule other patients who wish to be seen. If an appropriate notice of cancellation is given, there will be no fee imposed. ___ initial

If 24-hour notice of appointment cancellation is <u>not</u> given, please be advised that you will be charged a cancellation fee of $35.00. This amount is not covered by your insurance company, and will be the sole responsibility of the patient. ___ initial

I understand that I am financially responsible, whether my insurance company pays or not, for **all charges incurred by me**. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court cost and reasonable legal fees should such action be required. I agree that a photocopy of this authorization shall be valid as original. ___ initial

I have read and understand the above.

_____ _____

Signature Date

FINANCIAL COMMITMENT:

Person responsible for account:_____

Payment in full at each appointment, (insurance option to be discussed)

Please indicate method of payment:

__Cash __Check __Credit Card __Care Credit

If payment is not made in full within 25 days, a service charge will be added to the account at the rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00). Which is at an annual percentage rate of 18%.

$25.00 charge for each returned check.

AUTHORIZATION:

I herby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I herby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

_____ _____

Signature Date

__ Self __Parent __Guardian