CONSENT OF FINANCIAL RESPONSIBILITY

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dentist and staff will estimate insurance benefits as closely as possible. I also understand that I am responsible for payment of the account, and for providing correct insurance information.

I understand that if insurance is not applicable, when dental services are rendered; my full payment is due at the time of service.

Date:_____ Signature: _____

BROKEN APPOINTMENT POLICY

In our continuing efforts to provide quality dental services in a timely and affordable manner we request that a 24 hour advance notice is given if you need to cancel or re-schedule an appointment. By instituting this policy we will avoid overbooking our schedule to accommodate the amount of patients who fail to show up or cancel their appointment at the last minute. This policy should reduce long waits in the office and allow availability for emergency treatment. Confirming appointments is done as a courtesy to our patients and we will try to make every effort to contact each patient the day before a scheduled appointment. Thank you.