Patient Doctor Agreement

WHAT YOU CAN EXPECT FROM US

Our objective is to provide you, your family, and friends the very best quality dental care available in a unique environment, dedicated to your comfort and enjoyment. We stand behind the quality of our work.

WHAT WE EXPECT FROM YOU

Our patients are an elite group. They are health conscious, financially responsible, and expect the best care and service. They are prevention focused and appreciate the education that is required to adequately act as a team player with us in maintaining their dental health. They respect our time and we respect theirs.

PAYMENT

Regardless of any insurance benefits you may have, you are ultimately responsible for any treatment or service you elect to receive from this office.

Please select one of the following options:

☐ I do not have insurance or do not want my insurance billed and agree to pay at the time of service.

☐ Please submit claims to my insurance company as a courtesy to me. I agree to pay the ESTIMATED co pay at the time of service, understanding that it is only an estimate and insurance may not pay as estimated and I agree to pay the remaining balance. I also understand and agree that if my insurance company fails to pay your office within 60 days of treatment, I will pay the balance.

RETURNED CHECKS

A $30 processing fee will be assessed for any returned checks.

BROKEN APPOINTMENTS

If you are unable to keep a scheduled appointment we ask for 48 hours notice to make your appointment time available to another patient. There is a $50 charge for broken appointments.

I have read and understand this agreement.

Print Name _____

Patient Signature _____ **Date**_____

Doctor Signature _____ **Date** _____