



OFFICE POLICIES & FINANCIAL RESPONSIBILITY AGREEMENT

Please review the following policies carefully. Your signature indicates understanding and agreement.

Appointment & Cancellations

We reserve appointment times specifically for you. **A minimum of 48 hours' notice is required** to cancel or reschedule an appointment.

- Appointments canceled with less than 48 hours' notice, or missed appointments ("no-shows"), will be subject to a **\$50 late cancellation fee per hour reserved** for the appointment.
- This fee is **not billable to insurance** and is the patient's responsibility.
- Repeated late cancellations or no-shows may result in dismissal from the practice.

Insurance & Estimated Patient Responsibility

As a courtesy, we will attempt to **estimate your out-of-pocket cost** using the information provided by your dental insurance company. However:

- Insurance benefits are a **contract between you and your insurance carrier**, not the dental office.
- Estimates are **not a guarantee of payment**.
- You are ultimately responsible for understanding your insurance benefits, limitations, deductibles, and exclusions.

Payment Policy

- **Payment is due in full on the date services are rendered**, including any estimated patient portion.
- We accept payment via approved forms offered by the office.
- Any remaining balance after insurance processes the claim is the patient and is due upon receipt of statement.

Insurance Changes

It is the **patient's responsibility** to notify our office of:

- Any changes to dental insurance plans
- Terminated coverage



- Changes in subscriber, policy number, or employer

Failure to provide updated insurance information may result in the patient being responsible for the full cost of services rendered.

Acknowledgement & Agreement

I have read and understand the Office Policies outlined above. I agree to comply with these policies and accept financial responsibility for services provided.

Patient Name (Print): _____

Signature of Patient or Legal Representative: _____

Date: _____

If signed by legal representative, relationship to patient: _____