OFFICE POLICIES

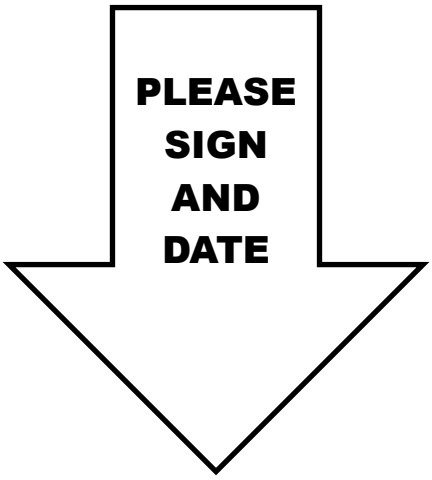
Patient:_____
Last **First** **Middle**

I, the undersigned, certify that I understand and agree to comply with the following office policies:

- Any appointment canceled with less than 24 hours' notice may be subject to a $50 cancellation fee, to be paid on the date of next visit. (We do understand that sometimes things happen – the fee may be waived in the case of a legitimate cancelation resulting from an emergency situation.)

- We want to treat patients who take their oral health seriously. Patients with an established history of missed appointments may be offered only last-minute availability when other patients have canceled, or even be subject to dismissal from the practice at the doctor's discretion.

- We are here to help our patients understand their insurance benefits and treatment options; however, it is the patient's responsibility to furnish all applicable information pertaining to their plan. We cannot always know what benefits have been used elsewhere, precisely what fee schedule is attached to the plan, etc. All treatment cost estimates provided are exactly that – estimates. Any amount not paid by the insurance company is the responsibility of the patient.



_____ _____/_____/_____
Signature of Patient, Parent or Guardian **Date**