LAUREL SMILES
DENTAL CARE

Payment/Cancellation Policy

Payment is required at the time of service. For your convenience, we accept Cash, Checks, Care Credit, Credit or Debit cards. Our office is happy to submit claims to your insurance company. I understand that Laurel Smiles Dental Care will make every effort to collect from my insurance company. I hereby authorize Laurel Smiles Dental Care to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that any amounts not covered by my insurance for any reason, I am responsible to pay unpaid balance.

Effective March 1, 2017, a new confirmation system has been put into place to assist with patient appointment confirmations. Please make sure before you leave that you have given us your preference of confirmation (Text or Email). You will receive a reminder based on your preference. If we do not receive confirmation via text or email a call will be made to you. You are still responsible for remembering your appointments in the event we are unable to reach you.

Cell # for text: _____

Email: _____

Broken dental appointments are a disappointment to everyone. They interfere with your dental treatment and create unnecessary scheduling problems for other patients as well as the office. If you need to change a scheduled appointment, we require **two business** days' notice. **If we do not receive advance notice of your need to change your appointment there will be a $50 charge per hour of appointed time.**

Our office reserves the right to re-appoint any scheduled appointment time if we do not receive a confirmation from the patient at least 24 hours in advance.

I understand that all payment for dental services is due in full, within 60 days from the date of service, regardless of whether my insurance payment has been received.

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

Patient: _____

Signature: _____

Date: ____ /____ /_____