Advanced
DENTAL CARE

Patient's Printed Name: _____

Financial Agreement and Authorization for Treatment

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment at the time treatment is rendered. I understand that if I have dental insurance, the office will estimate my possible benefit for treatment and require that I pay for the portion not covered by the insurance at time of treatment.
As a courtesy and a help to me, the office will make every effort to assist me in getting the maximum benefit available but will not guarantee any estimated coverage. **Upon acceptance of treatment I will be accepting the office fees and committing to the total dollar amount of treatment regardless of any insurance benefits. All charges shown are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I understand that a fee of 1.5% will be charged per month on any unpaid balance.** If my account is 90 or more days past due, it will be turned over to a collection agency. Any charges incured to collect the balance on my account, which includes collection agency fees, billing fees, court costs and attorney fees, will be added to my unpaid balance due to be paid by me or my representative (i.e. family or spouse, as it applies).
A $25.00 fee will be charged for any personal check returned for insufficient funds.

(A copy of this assignment is as valid as the original)

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(Signature of patient or patient representative and date)

Appointment Policy

Our fees represent the high quality of service and care that you receive here at Advanced Dental Care. In order for us to maintain our affordable fees and high quality of service, we must ask for your cooperation and respect in regards to our appointment policy. When you schedule an appointment with our office, we reserve that time specifically for you because we know your time is valuable. We provide several reminders before your appointment in either an email, text or phone call.

We request at least **48 hours cancellation notice,** as we have a long wait list for appointments. **If you give less than 48 hours notice or do not show for the visit, the appointment may be considered a "No show or fail", and you will be billed an office visit charge of $50.00 per hour that was originally scheduled.**

So, if you must cancel, please make sure you give us 48 hours notice. We appreciate your understanding and respect in this matter.

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(Signature of patient or patient representative and date)

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