# DOVE FAMILY DENTISTRY

## Patient Agreement Form

**By signing this document, you acknowledge that you have read and consent to the terms below. Please initial the boxes and sign in the space provided below.**

### FINANCIAL POLICY

Financial arrangements are made prior to treatment. Our fees remain the same independent of insurance coverage. All checks are subject to a reprocessing fee of $27.00.

Without dental insurance, full payment is required at the time of service. If you have dental coverage, the difference between the total fees and estimated insurance payment will be due at the time of treatment.

You will receive a current monthly statement, even though your insurance carrier may not have paid yet. When payment is received from our insurance, your next statement may reflect a balance due.

☐ **I have read and reviewed the Financial Policy and consent to the terms**

### CANCELLATION / NO SHOW POLICY

I am aware that there will be a **$75 fee** (for hour appointments) and a **$125 fee** (for 1.5+ hour appointments) canceled or rescheduled without **(2) business days' notice.** I acknowledge that if I miss two appointments, I may be moved to walk-in status (or day-of appointments only). We may require a credit card to be kept on file in order to reschedule.

☐ **I have read and reviewed the Cancellation Policy and consent to the terms**

**Please review that all boxes above have been read and initialed, then sign and date below.**

Print Name: ______________________________ Signature: ______________________ Date: _______

Name of Responsible Party (If different from patient listed above)

Print Name: ______________________________ Signature: ______________________ Date: _______