Financial Responsibilities

Welcome to our practice. We are very glad that you chose our office. We are here to provide the most quality dental care available. We want to be concerned with your dental care not financial responsibilities. Therefore, we will do our best to provide as much information as you need to understand your dental needs and treatment. To this end, we will do our best to estimate the costs of your quality care. We want to avoid any misunderstanding so please feel free to ask any questions you may have.

Payment is expected at the time of service and you are responsible for any expenses your insurance chooses not to cover. We accept Visa, MasterCard and Debit cards.

Late fees, and rebilling fees may be included if payment is not paid on time, (not to exceed $10.00 per occurrence).

No Show and Cancellation Policy

We require a 24 hour notice if you can not make your scheduled appointment. If you are unable to make your appointment due to an emergency, we will understand. ALL NO SHOWS and CANCELLATIONS without 24 hours notice are subject to a cancellation fee. The fee is $50.00 per scheduled hour for Hygiene time and $100.00 per scheduled hour for Doctor time. If there are repeated abuses of our time it could result in your dismissal from our practice. As a service Advance Dental Arts Center tries to provide an appointment confirmation call to our patients, a day or two before your appointment. Please let us know the easiest way for us to do this, phone or e-mail?

_____

E-mail address for scheduling confirmation

General Release

The undersigned hereby authorizes the doctor to take radiograph, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, dedication and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that the doctor choose and refer to a specialist as she deems fit. I understand that the use of anesthetic agents and certain treatment embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed.

Date:_____

_____ _____

Signature of Patient Signature of Parent or Responsible Person (Relationship)

Thank you,
Kimberly Wright, DMD, PC