PATIENT INSURANCE RESPONSIBILITY

I authorize and request my insurance company to pay directly to the Dentist or Dental Group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and that my deductible may apply to my first visit once insurance has rendered payment. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

CANCELLATION POLICY

Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $25 cancellation fee for your general dentist and $50 cancellation fee for the specialist. If commitments for appointments are frequently broken, a nonrefundable reservation fee equal to the appointment fee may be required.

Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal.

X_____

Thank you.

Strong Roots Dental PC

4