

**Marion Dental Health
3 Spring Street
P.O. Box 949
Marion, MA 02738
(508)748-0744**

Dear Patient,

We believe that a clearly defined office policy will allow both you and the doctor to concentrate on the main issue, regaining and/or maintaining your dental health.

Appointment Policy:

We ask that all patients be punctual, appointments are based on the time needed for each service. There are often several providers working so we ask that you understand other patients may be called in before you. We will do our best to stay on schedule but emergencies do happen which sometimes alter our timing. Please help us to serve you better by keeping all scheduled appointments. If you need to cancel appointments after hours you may leave a message on our answering machine. We reserve the right to refuse any patient who misses appointments. **It is our policy to charge up to \$100 (fee based on appointment scheduled) for any missed appointment, or those that are not cancelled at least 24 hours in advance.**

Financial Policy:

Payment is due at time of service. If you have insurance , your estimated co-payment is due at time of service. This office will process insurance forms and mail statements when necessary. We cannot guarantee that your insurance company will pay for any of the fees you incur, nor will we enter into any dispute with your insurance company over reimbursement. Ultimately payment is the patients responsibility. Regardless of the insurance company's determination of usual and customary fees or amount of assignment, you are responsible for the remaining balance.

Any balance that is not paid in 60 days will be subject to 1.5% interest charge. In the event of default, the reasonable collection charges and attorney fees will also be your responsibility. Please let us know if you have any questions or concerns.

I have read and understand the above policies.

Patient Name/Signature: _____ Date: _____

Parent/Guardian signature (if patient is a minor): _____