**Marion Dental Health Associates, P.C.**

**3 Spring Street**

**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 restoring and maintaining your oral health.

**Appointment policy:**

We ask that all patients be punctual as 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 can alter our timing. Please help us to serve you better by keeping all scheduled appointments. If you need to reschedule appointments after business hours you may leave a message on our answering machine. 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 the time of service. If you have insurance, your estimated co-payment is due at the time of service. Our 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. Regardless of the insurance company’s determination of usual and customary fees or amount of assignment, you are responsible for the remaining balance. Final payment is ultimately the patients responsibility.

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.

By signing, I acknowledge that I have read this consent form and agree to the contents.

Patient name/signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian signature (if patient is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_