Smile LA Dental

5. FINANCIAL POLICY -Smile LA Dental

Patient's name	PATIENT, NAME
Chart#	1

Welcome to Smile LA Dental. We would like to let you know that you are in great hands.

We will strive to provide you with the best service that we possibly can. Please understand that in order to do this, we must enforce the following policies:

1. Full payment is due at the time of service unless prior arrangements are made.

2. All co-pays are collected at the time of treatment rendered.

3. Adults accompanying minors are responsible for the child's treatment fees at time services rendered.

4. There will be a $20 charge for broken appointment without at least 24 hr cancellation notice.

I, _______________, read and understand the above FINANCIAL POLICY and agree to comply with them. I understand that I am responsible for ALL fees regardless of insurance coverage. I also understand that as treatment progresses, the fees may have to be adjusted, but that I will be informed of these adjustments and how they will affect my payment plan. In event that any payments are not received within 30 days of their due date, I agree to pay all cost of collection. I authorize the use of my signature on all of my insurance submissions.

____________________________	____________________________	____________________________
Patient/Responsible Party Name	Signature	Date