Thank you for giving us the opportunity to help meet your oral health goals. During our discussion of your treatment recommendation and our Written Financial Policy, the following financial arrangements were made:

Your ESTIMATED cost for treatment today is $________________________. This amount will be due TODAY. Once your consult and dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if that occurs.

________________________________________ **Patient Signature**

We have spoken with your insurance company regarding your dental benefits. Please remember the portion discussed is only an ESTIMATE of what your insurance will cover.

IF they do not pay their estimated amount, you will be responsible for paying the difference. Failure to keep your account current will result in your account being sent to collections.

The ESTIMATED cost that your insurance will cover is $_______________________

_________________________________________ **Patient Signature**

**Cancellation Policy**

Confirmation calls are done 2 business days in advance to your appointment and we do appreciate a call back if a message is left to confirm your appointment. If you need to cancel or reschedule, a 24 hour notice is appreciated. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

___________________________________________**Patient Name** __________________**Date**