

W. David Christenbery DDS

Financial Policy

This office makes every effort to work with our patients on financial matters. If you have dental insurance we will file it for you. However, the agreement with your insurance company is between you and your insurance company. We may estimate the portion they will pay toward your dental treatment, but it is an estimate. You are ultimately responsible for your account. We will ask that you pay for your deductible and an estimated portion of your treatment fee at the time of service. If you do not have dental insurance, we request payment in full at time of service unless other arrangements are made in advance and in writing.

I am responsible for this account.

Patient or responsible party _____

Date: _____

Attendance Policy

We understand that on occasion cancellations are necessary. Please remember that each appointment time is reserved exclusively for the individual patient, and without adequate time to fill the broken appointment, the operator is empty for that time. Unfortunately, the overhead for the operator continues. Therefore, if we are unable to have two full business days notice of a cancellation during our normal hours, a fee of 50% of your scheduled charges may be assessed to your account. We would prefer to never make that charge. Please arrange your schedule to keep your appointments.

I hereby acknowledge that I have read and understand the above paragraph.

Signed _____ Date _____