FAMILY DENTISTRY
OF UPPER MARLBORO

***This form is an act of your acknowledgement to our offices policies. Whether agreed to them or not, these polices apply to each and every patient seen within our office. ***

Financial Policy

As courtesy to our patients we will submit claims to your insurance company once. In the event that they **DO NOT** pay or reject the claim for any reason **YOU** will be **responsible to pay the total charges**.

When scheduling a future treatment appoint a **50% payment** of the estimated charges is required.

- Initial-I have read and understand: _____

Appointment Cancellation Policy

Many patients are waiting to schedule an appointment at our office, when someone does not keep an appointment it not only disrupts our schedule but prevents other patients from scheduling. Due to this situation we **REQUIRE 24 hours' notice for cancellation**. If you **fail** to notify our office OR no call, no show to your appointment there is a **$25.00 fee per appointment per patient.** This fee must be paid in order to schedule any future appointments.

- Initial-I have read and understand: _____

Running Late?

If you are running late to your appointment, we **require** you to call our office and inform us. Failing to notify us that you are running late results in our schedule running behind. If we are notified that allows us time to adjust. We will **allow a 15-minute** late window. We try our hardest to see everyone, however, if you arrive to your appointment more than 15-minutes **after** the scheduled time you may have to be rescheduled.

- Initial-I have read and understand: _____

Patient name: _____

Patient Signature: _____**Date**: _____