All Smiles Dental Cancellation Policy

Patient Name: _____ (Please Print Clearly)

Please be advised that we require a minimum of 24 hours notice to cancel a scheduled dental appointment. This allows us the opportunity to offer the time reserved for you to someone else.

If you have a scheduled appointment and do not call to cancel the scheduled appointment within the 24 hours required you will be charged $50.00 for every hour that was reserved for you.

The second time a 24 hours notice is not given, you will be offered 30 day emergency treatment and you will be dismissed as a regular patient from this practice.

All Smiles Dental Patient Insurance Payment Policy

Breakdown of coverage and when payments are due effective 4/7/16

Preventive: All Smiles Dental accepts insurance payments directly for most dental insurance companies for preventive treatment. This consists of exams, x-rays, dental sealants and simple cleanings. Payment for adult fluoride treatment will be due at the time of service. Once payment is received from the insurance company, you will be billed directly for any remaining balance.

Basic and Major Restorative: All Smiles Dental requires that patient's pay whatever their dental insurance does not cover at the time of service for any type of basic or major treatment. If you do not have dental insurance, payment is due in full on the day the treatment starts less any deposit you have already made.

Appointment Reservations: Any type of treatment requiring more than 60 minutes of scheduled time other than a new patient visit will require a $100.00 deposit at the time the appointment is scheduled. Those appointments scheduled via telephone may be reserved with a credit card (we honor Visa, MasterCard, Discover and Care Credit). The $100.00 deposit will be applied toward the cost of treatment once the appointment is completed. The $100.00 deposit will be forfeited should any appointment be cancelled or rescheduled with less than 24 hours notice.

My signature below indicates that I have read, understood and agree to the above listed terms and information in the cancellation and insurance payment policies.

_____ _____

Signature of patient or parent/legal guardian **Date**