

FINANCIAL RESPONSIBILITY AND CANCELLATION POLICY
FINANCIAL AGREEMENT

I acknowledge and agree that I am responsible for and will pay for all regular charges which are contained in the applicable dental procedure provided by *Renaissance Dental*. I agree to pay for all regular charges incurred on the dates of services rendered for items and/or services provided to Patient, including any amount not paid by my insurance plan for their treatment.

I understand that I am personally responsible for any item or service determined by my third party payor (my insurance company) to be experimental, investigational or to be non-covered for any other reason.

I am also aware that according the Senate Bill AB72 I give my voluntary consent to be treated for care even if my insurance is out of network. Renaissance Dental is given permission to bill my out of network insurance company and I will be responsible for all co-pays or balances, including any amount not paid by my insurance plan for the treatment.

CANCELLATION POLICY

I understand that if I need to change an appointment, I must give at least 48 hours notice to *Renaissance Dental* prior to my appointment. ***There is a charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in pre-payment for any future treatment.***

Please read and sign our policy as indicated below:

- Please note: this missed appointment fee is NOT covered by insurance plans and is your responsibility to pay within 30 business days.
- If you need to cancel or reschedule an appointment, please give us at least 48 hours notice in advance to avoid a charge. If notice is left on our answering machine, then the notice will be counted from our next regular scheduled business day when we receive the message.
- If you fail to arrive for your appointment and have not notified us at least 48 hours in advance, you will be charged for a missed appointment.
- If you miss *three* appointments, we will require you to pay in advance for your visits.

Hygiene Appointment - \$85.00 Dentist Appointment – 35% of Treatment Scheduled

Thank you for your assistance in complying with our policy.

I HAVE READ THE ABOVE INFORMATION, UNDERSTAND IT, AND CONSENT TO IT.

Patient Name (please print)

Date

(Patient/Legal Guardian Signature)