PANATELLA DENTAL
™

OFFICE POLICIES

APPOINTMENT REMINDERS

Please understand that it is **your responsibility** to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment.

CANCELLATIONS

Please provide us with a **minimum of 24 hours notice** per appointment should you require to reschedule your appointment (48 hours notice for Monday appointment times). This is valuable time that the Dentist/Hygienist has reserved for you. In the case that insufficient notice is given a **$55.00 fee** will be charged to you.

OFFICE PICTURES

The office takes patient pictures for a variety of reasons, primarily to add to a patient file, before and after comparative images, and for children to be added to the Squeaky Clean Club wall.

DIRECT BILLING INSURANCE & PAYMENT ARRANGEMENTS

The Canadian Personal Privacy Act prohibits us from accessing any information from your insurance carrier. It is **your responsibility** to know the details involved in your plan (annual maximums, frequencies, other limitations). We extend the **courtesy of submitting paperwork to your insurance company**, however, to avoid any discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to the maximum.

Below are 2 payment options available to you. Please **circle** which option you would like to participate in.

OPTION 1

Payment is due **in full** at time of service. We accept cash, Debit, Visa, MasterCard & American Express. Your payment will be processed & insurance documents will be generated to submit to your insurance carrier. An insurance cheque will be sent directly to you from your insurance carrier.

OPTION 2

If you require financial assistance, we would be happy to handle all paperwork and deal with your insurance carrier directly. However, you will be required to leave a credit card number on file & your portion will be applied to that credit card once your insurance carrier has paid us its portion. A receipt for payment can be emailed to you. If you would prefer not to leave a credit card number, Option 1 would be your choice.

I have read, understood and agree to the Office Policy and Privacy Policy on the back page.

_____ _____

Patient/Guardian Signature Date

OPTION 2 ONLY

I hereby authorize any outstanding balances not covered by my insurance carrier to be automatically applied to:

Credit Card (circle one): Visa MasterCard American Express

Card #:____/____/____/____ Expiry Date: ____(mm/yr) Name (on credit card): _____

Signature of Cardholder: _____