

Welcome to my dental practice. My staff and I would like to thank you for your confidence in our work. We are here to help you attain and maintain optimal oral health. We will provide excellent dental care with a holistic and total wellness approach. Our "reason for being" is to help you smile!

— Dr. Regina M. Dailey

Please review the following policies:

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## Cancellation Policy

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible.

When patients give the office advance notice of their need to change a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way the office can best serve the needs of ALL patients.

Bearing these special needs in mind, the office requires a minimum of 48 hours notice if an appointment must be cancelled. If less than 48 hours notice has been given to cancel an appointment, a \$50.00 fee may be assessed. In the event that no notice is given and the patient fails to keep his/her scheduled appointment, then a \$75.00 fee will be assessed. Please note that this fee is not covered by dental insurance and payment is the patient's responsibility.

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## Payment Policy

In order to assist you with payment methods available, we have listed various options below. As a courtesy, we will file your dental insurance for you.

It is the patient's responsibility to cover procedures that are not covered by his/her insurance plan. Please note that your insurance carrier may not cover all services and every insurance plan has its own unique guidelines and exceptions. If you have any questions regarding these options, please direct them to a staff member.

Please indicate your preference:

Cash, check or money order

Credit card (Visa, MC, Disc, Amex)

Acct number: \_\_\_\_\_ Exp. date: \_\_\_\_\_

Signature: \_\_\_\_\_

Care credit

A line of credit for your dental treatment — monthly payment option available.

An application is available in our office.

Dental benefits/insurance

Our office will collect your co-payment the day of service and bill your insurance company using the information given to us.

We are happy to do this as a courtesy to you and expect payment from your insurance company within 60 days. If payment is not received, we expect payment in full from you. We ask that you authorize us to transfer the unpaid estimated insurance balance to your credit card. Any payment then received from the insurance company will be forwarded to you.

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## Agreement

We hope this information adequately explains the options available to you. Please sign below to indicate your acceptance of these policies and the payment plan(s) selected above.

\_\_\_\_\_  
Authorizing signature

\_\_\_\_\_  
Date