LANCASTER SMILES

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APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and keep your time spent in our reception area as short as possible. In return, when you make an appointment with us, please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. Please provide us with at least 2 business days of advanced notice so that we may use our time to accommodate other patients.

Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours. A missed appointment fee of $100 may be charged for broken, changed or rescheduled with less than 24 hours' notice. This must be paid prior to rescheduling.

FINANCIAL POLICY

We have an obligation (by contract) with your insurance company to collect all co-pays at the time of your visit. Payment is due at the time of services.

Finance Charges and Fees.
1. Balances in excess of 90 days without prior arrangements will be referred to collections.
2. Returned checks are subject to a $35 accounting fee and will be reported to Bad check Restitution Program of Lancaster County District Attorney's office.

AUTHORIZATION AND CONSENT

As a general consent to treatment I agree and consent to all necessary x-rays, exams, and hygiene procedures performed by Lancaster Smiles. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I authorize Lancaster Smiles to release any information regarding my dental/medical history diagnosis or treatment to third party (insurance or whom I authorize as payor) payors and/or other health professionals in direct care of my dental/medical health.

Patients are responsible to set up assignment of benefits with their insurance to assign Lancaster Smiles as the assignment of benefits so insurance will pay directly to us on your behalf the benefits provided by your insurance carrier.

I understand and will comply with the Lancaster Smiles Appointment Policy.
I understand and will comply with the Lancaster Smiles Financial Policy.
I understand and agree to the General consent to treatment.
I authorize the Release of Information to third party payors (i.e. insurance or authorized payor I have provided) and health professionals in my direct care.

_____	_____	_____
Patient or Legal Guardian Signature	Print Name	Date