

Smile Source Spokane

Financial Policy

**Patient Agreement and Financial Policy**

I hereby agree to be responsible for the costs of care provided by Smile Source Spokane and/or the dental team for myself or my dependent(s).  These include any deductibles and amounts not covered by insurance.  **I also understand that it** **is my responsibility to be aware of any limitations, and benefits of my insurance policy.**  Payment to this office is my responsibility, and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

**I understand that if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time, a $50 fee may be applied to my account.**  We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule.  These appointments are reserved exclusively for you.  In return, we ask that you make every effort not to change your reserved dental appointment.

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