PLEASE READ THE FOLLOWING CAREFULLY

FINANCIAL & CANCELLATION POLICY

FINANCIAL RESPONSIBILITY AGREEMENT: As a courtesy Masterpiece Smiles will file all dental claims to insurance company. This will prevent me, the patient, from having to pay in full at each visit. I understand that the information of my plan benefits given by my insurance company is "not a guarantee of payment". I understand that my insurance company may deny payment for certain procedures or treatments. These procedures and treatments may not be covered benefits or the insurance company may later decide that they were "not reasonable", "not medically necessary", or "experimental and investigational". If my insurance company denies payment on a procedure or treatment provided by Masterpiece Smiles, I agree to be personally responsible for payment in full of all services rendered.

CANCELLATION POLICY: If you need to cancel, please do so 48 hours (two business days) in advance of your scheduled appointment time*. *If you are running more than 15 minutes late for an appointment, your appointment will be rescheduled and will count as a cancelled appointment.*** This office reserves the right to charge a $50 per hour fee for missing an appointment or canceling with less than two business days' notice. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you. If your appointment is not kept, other patients who may need same day visits or earlier appointments are obliged to wait longer than necessary.

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Signature of Patient or Guardian Date

ACKNOWLEDGEMENT OF RECEIPT/REVIEW OF NOTICE OF PRIVACY PRACTICES

I, _________________________________ have received/reviewed a copy of this office's Notice of Privacy Practices and Hippa Laws and Regulations.

____ ________________
Signature of Patient or Guardian Date