FOR OUR PATIENTS INFORMATION

Welcome to our office. This statement of our policies is made to avoid possible misunderstandins concerning treatment, appointments, and payment. This permits us to devote a maximum amount of time and attention to our first concern - you.

Appointment Commitment

We reserve the time for each patient in our practice, and we make every effort to respect your time by running on schedule. Please give us 24 hours notice if you will be delayed or must reschedule your appointment. We request 48 hours notice for long appointments of an hour or more. Please do not cancel appointments on the voicemail because it does not allow the front office an opportunity to reappoint you and it keeps patients waiting who are on the quick call list and may be in pain. Patients who routinely cancel appointments suffer dangerous delays in completion of treatment and may be dismissed from the practice There will be a $100.00 cancellation charge if 24 hour notice is not given.

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Initials

Commitment to Treatment

We believe necessary treatment should be completed in a timely manner. Incomplete treatment leads to complication, possible pain, and tooth loss for the patient. It is our goal to save your teeth and maintain your dental health. The dentist and patient must have mutual health goals and a reasonable time frame to successfully complete treatment.

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Financial Commitment

We feel we have a responsibility to use our best care, skill, and judgement in planning your dental treatment. We will propose a treatment plan for you with a review of our findings, and your input is respected and valued. Your signature indicates that you are willing to accept and pay for treatment that is rendered. We provide professional services to you, not an insurance company. If you have insurance, we will help all we can in submitting forms within the limits set by The American Dental Association. Please understand that insurance companies pay only a portion of the fee, if at all, and the balance is payable at each visit. We are happy to help you with any financial and insurance questions you may have.

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Initials

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM. I HEREBY AUTHORIZE THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME RO BE PAID DIRECTLY TO EMILY MANGOHIG-WENZEL, D.D.S.

Signature__________________________