APPOINTMENT AND PAYMENT POLICY

- Please read and sign the following:

1) Full payment is due at the time of service. We accept Cash, Check, Visa, Mastercard and Discover.

2) As a courtesy, we will submit your bill to insurance (dental and/or medical). Submittal is not a guaranty of payment. THE PATIENT IS RESPOSIBLE TO KNOW THEIR COVERAGE AND PAY IN FULL ANY REMAINING BALANCE.

3) I understand that I am responsible for any portion of fees for services rendered that we not covered by dental or medical (if any).
   _____ **Patient initials**

4) I further consent to and agree to pay a 1 ½ % finance charge (18% annually) or a minimum of $20.00 rebilling fee for any balance over 30 days.
   _____**Patient initials**

5) Accounts that are outstanding for longer than 40 days will be sent to collections. I realize that I am responsible for all fees associated with collecting my balance.
   _____**Patient initials**

6) Your scheduled appointment is your confirmation. There is a **minimum $90.00 fee** for broken appointments. We also require a 48 hours' notice for any appointments that need to be rescheduled.
   _____**Patient intials**

_____ _____ _____/_____/_____

Patient Name **Patient Signature** **Date**

AESTHETICS IMPLANTS RESTORATIVE PREVENTATIVE SURGERY