

**2431 Easton Avenue, Bethlehem, PA 18017 (610) 861-0190**

**1050 S. Cedar Crest Blvd., Suite 104, Allentown, PA 18103 (610) 973-2090**

**Office Policies and Procedures**

* The Dentist have reserved valuable time for your appointment. Please honor the scheduled appointments and arrive on time. If you are unable to keep your appointment a 48hours notice is required, otherwise a **$50.00 fee** will be charged to your account.
* **Deductibles** (if applicable) and **co-payments** for services rendered are **due at the completion of the visit.** Due to increasing incidence of NON-PAYMENT by patients for services rendered, all outstanding and overdue balances will be collected prior to being seen for any Non-emergency office visits**. ALL CO-INSURANCE AND VISITS NOT COVERED BY YOUR INSURANCE WILL BE COLLECTED AT THE TIME OF SERVICE.** We give estimated amount due the fact your insurance plan may use a different fee schedule then what is supplied to us from your insurance plan.

**IF YOU ARE UNABLE TO MEET THESE REQUIREMENTS PLEASE INFORM US PRIOR TO YOUR VISIT SO THAT WE CAN RESCHEDULE YOUR APPOINTMENT.**

**This policy has been approved and agreed by all physicians in this practice**.

* (*If applicable*) I am the parent, guardian or representative of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please print name of minor/child)

and there are no court orders now in effect that prohibits me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child name above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the dentist, whether or not I am present when the treatment is rendered.

* **Simple Agreement**: Patient authorizes the Doctor to deposit checks received on patient’s accounts and authorizes credit card payments by phone and mail.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that if I am delinquent on my obligation to pay Gentle Family Dentistry, then I will be responsible for any fees, interest charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence.

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

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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