Patient Financial Agreement Form

WELCOME

In our pursuit of excellence in the art of dentistry, we are committed to make caring for our patients' dental health and well-being our top priority, to provide state of the art facilities and to use the most current procedures available to ensure our patients ' health and comfort, and to be courteous and kind to all people and build lasting friendships with our patients.

APPOINTMENTS

Following your visit today, you may be given additional appointments. We look forward to seeing you at the appointed time(s).
WE URGE YOU TO KEEP THESE APPOINTMENTS, DUE TO LIMITED TIME AND SPACE. Broken or failed appointments can compromise your oral health and will result in the loss of valuable professional time. If you need to cancel or reschedule your appointment, please give us at least **48 HOURS NOTICE,** to avoid being charged a **BROKEN APPOINTMENT FEE OF 20% OF YOUR TOTAL TREATMENT FEE SCHEDULE FOR THAT DAY.**

WHEN YOU USE YOUR INSURANCE

Please sign below if you understand & agree with this document & with the treatment provided.
Insurance estimates are not a guarantee of dental benefits.
If you have any questions regarding dental benefits coverage, please ask or refer to your benefits booklet.

PATIENT'S INITIALS_________

*If we are able to assist you & accept assignment of insurance, and for any reason, your insurance carrier elects not to reimburse Copenhaver Dental for treatment rendered, we ask that you authorize us to debit your credit card for the unpaid balance not paid in full within **40 days.***

PATIENT'S INITIALS_________

credit card number	exp date	amount	debit date (1st or 15th)

I,______________________________, hereby understand the above statements and agree to meet the requirements.
(Print Full Name)

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Patient Signature Date

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Staff Signature Date