Smith Family Dentistry
Family, Cosmetic and Implant Dentistry

Office Appointment Policy

Our objective is to provide you with the highest quality dentistry available. To accomplish this it is imperative that you keep your scheduled appointments so that we may perform all your treatment in the proper sequence and in a timely manner. We realize that unexpected things do come up that require you to change your plans. We would appreciate 24 to 48 hours notification of schedule changes. If inadequate notification is given, we reserve the right to charge a $50 fee for your appointment time. If subsequent appointments are missed, we will call you when a time slot becomes available. As a courtesy, we will send you an automated email or text message confirming your upcoming appointments. Please provide us with your contact information. Your cooperation is greatly appreciated.

Office Payment Policy

In order for us to provide you with the highest quality dental care, it is necessary for us to collect our fees as treatment proceeds. Those patients with dental insurance will need to make their co-payment at their office visit. Those patients without dental insurance will be required to pay for treatment in full at the time of the visits, unless other payment arrangements have been made.

Please ask our Office Manager about the affordable monthly payment and zero interest payment options we offer-options that can make it easy to fit your dental care into your budget.

A 1.5% monthly interest charge may be added to all account balances over 60 days.

We will gladly file your insurance for you. However, you must supply us with complete and accurate insurance information and keep us updated with any changes in your coverage. Because insurance companies do not guarantee benefits, payment is ultimately your responsibility.

We try to make each visit to our office an exceptional experience. When we succeed, we would welcome your telling your friends and co-workers about our office. Your referral is the highest compliment we can receive and is greatly appreciated.

Thank you for your cooperation.

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Patient Name (Please Print) Date

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Patient Signature (Parent/Guardian if Patient is a Minor)