SMILES OF BUFFALO GROVE

Welcome to our practice! We are happy that you selected our office for your dental needs. We are committed to the success of your dental treatment. To assist you in understanding our requirements in addition to your financial responsibilities relating to your dental care, we would like you to read this policy and acknowledge it by signing on the bottom of the page.

1. I will inform Smiles of Buffalo Grove of any changes to my dental insurance carrier, home address, contact information as well as credit card information.
2. I understand that all my payments or insurance co-payments are due at the time of service.
3. I understand that if my insurance doesn't cover my dental visit or once my insurance carrier has paid their portion of my office charges, it will be my responsibility to pay the remaining balance.
4. I understand that there is **$75** charge for **NO-SHOWS** and **CANCELLATIONS** made less than **48 hrs** in advance of my scheduled appointment.
5. I understand that should I arrive late for my scheduled appointment, it will be at the office/s discretion if I will be seen or if I need to reschedule my appointment and/or if I will be charged as a NO-SHOW.

_____ _____

Pt/Guardian Signature Date

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Pt Name