



Valerie Reese, DMD

General Office Policy:

- ❖ I understand the majority of dental appointments are available during school and work hours.
- ❖ I understand **I should give a two day notice** when I need to reschedule my child's appointment.
- ❖ I understand my appointment may be **postponed or rescheduled if I am late.**
- ❖ I understand **failure to show or a cancellation without sufficient notice may discontinue my ability to make multiple family appointments on the same day. Each child may need to be scheduled on a different day.**
- ❖ I understand my records may be duplicated and transferred for a reasonable fee.
- ❖ I understand the office will inform me of their knowledge of what my insurance coverage is, but it is my ultimate responsibility to know my child's insurance coverage, frequencies and benefits.
- ❖ I understand my deductibles and estimated co-pays **are due in full at each visit.**
- ❖ I understand I am responsible for any unpaid balances on the part of my insurance company.
- ❖ I understand I will be reimbursed or credited for any overpayment of dental services.
- ❖ I understand the Doctor and staff welcome all questions.

_____/____/____
Printed Parent's (Guardian) Name Date

_____/____/____
Parent's (Guardian) Signature Date

Child's Name _____ D.O.B
