BAY AREA ENDODONTICS

Patient Name:_____ **DOB:**_____

OFFICE FINANCIAL POLICY

PAYMENT IN FULL IS REQUIRED AT THE TIME SERVICES ARE RENDERED

Accepted forms of payment Visa, MasterCard, Discover, American Express, Care Credit, Cash or Check

I understand and agree that payments made by major credit card will be subject to a processing fee for expenses incurred by the office and/or its business support provider. This is an automatic charge by the merchant bank and cannot be adjusted. To avoid processing fees, use an alternate form of payment listed above.

I understand and agree that payments made by check that get returned unpaid by the bank will result in a fee of $40 plus any additional fees charged by the banks. And checks will no longer be an acceptable form of payment in this office or any affiliated offices.

I understand and agree that any unpaid balance remaining after 90 days will be sent to our Collections Agency and that I am responsible for any costs incurred in collection of the said balance should that become necessary.

I have read the financial policy, and I am aware payment is due at the time of service, no exception. In-house payment plans are no longer an option.

APPOINTMENT CANCELLATIONS & LATE ARRIVALS

Kindly give 24 hours notice when making changes to your appointment

I agree that if I am unable to keep my scheduled appointment, I will contact Bay Area Endodontics *at least* 24 hours prior to my scheduled appointment time to reschedule.

I understand that I will be charged a fee of $75.00 if I fail to give any or less than 24-hour notice. We do understand that emergencies happen and will work with you in the case an emergency does arise within the 24-hour window.

Arriving more than 5 minutes past your scheduled appointment time may result in the need to reschedule or cancel your appointment. For appointments requiring paperwork to be completed, you **MUST** arrive 30 minutes prior to your schedule arrival time to avoid having to reschedule.

By signing below, I am acknowledging that I have read and understand the above policies and agree to comply.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE