OFFICE POLICY

COMMITMENT TO SCHEDULED APPOINTMENTS:

Our office reserves time for each patient in our practice. An appointment written in our schedule with your name on it is a **bond of trust** that we will be here to serve you and that you will be present for your appointment. Therefore, our policy in this regard is firm and inflexible. You must be present for all scheduled appointments. We do not allow consistent short-notice changes. Your signature below indicates that we must have mutual respect for each others time.

COMMITMENT TO TREATMENT:

All treatment that has been started should be completed. Incomplete treatment leads to problems, complications, and misunderstandings. Incomplete treatment can also lead to loss of teeth and further disease. Therefore, all agreed upon treatment plans, once they are started should be completed. Some treatment plans may take years to complete. However, to begin a staged treatment plan, your commitment to both starting and completing treatment is essential.

COMMITMENT TO FINANCIAL AGREEMENT:

Our office has a responsibility to use our best professional care, skills, and judgment in planning your dental treatment. The benefits and liabilities of treatment or lack thereof are always explained to each patient with a written treatment plan in each chart. By signing below, you have indicated that you agree that all fees should be properly explained to you and that you agree to fulfill your financial commitment to our office promptly and completely. No practice or business can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services.

PATIENT _____ DATE _____

DOCTOR _____ DATE _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to Dr. Reisterer all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all other charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: _____ Signature: _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____