BROKEN APPOINTMENTS
Reserved appointment time in any dental office is limited and valuable. For this reason, it is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, failure to give such notice of inability to keep a scheduled appointment (48 hours advance notification) will result in a fee being charged. That charge will apply to all our patients and is to be paid prior to scheduling of any new appointment. Insurance does not cover this expense; the patient is solely responsible for this charge.

The fee for broken appointments to our office is $50.00.
Please feel free to discuss this with our staff if you have any questions.

FINANCIAL RESPONSIBILITY
The following is to clarify the financial responsibility of dental services provided:

I understand that responsibility for payment for dental services provided by Dr. Campbell’s dental office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand and agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 33\% of the debt, and all costs, and expenses, including reasonably attorneys’ fees that are incurred in such collection efforts. I also understand there is a $25.00 returned check fee.

CONSENT FOR TREATMENT
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient’s dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient)_______________________________ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient or Parent Signature____________________________________________Date___________________

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