Eberhardt Dental *Family Dentistry with a Cosmetic Touch!*

August A. Eberhardt, D.M.D. *Alan C. Eberhardt, D.M.D.*

I, _____, am financially responsible for services not covered by my insurance company. These charges are due in full at the time of service, up to and including: co-pays, deductibles, and fee co-balances or any balances rejected by your insurance company.

Overall knowledge of the Patients dental insurance policy is the responsibility of the Patient, Parent, or Guardian. Our office will pre-determine the recommended treatment plan, but overall knowledge of the policy lies with the Patient, Parent, or Guardian.

In addition, I also agree to pay any and all cancellation fees for scheduled appointments in which I fail to give at least 48 business hours notification stating that I will be unable to attend. Fees to be applied for "No Show" or cancelled appointments with less than 48 hours will be $65.

Signed,

_____

Date: _____

748 MILFORD ROAD EAST STROUDSBURG, PA 18301 570 424 2445