WELCOME TO CREEKSIDE DENTAL
New Patient Agreement

I,________________________________, understand:

The financial policy of this clinic is to pay at the time that services are rendered.

I am responsible for all the fees incurred for my own treatment and/or for the treatment of a minor that I am responsible for, **regardless of insurance coverage.**

As treatment progresses, fees may have to be adjusted, but I will be informed of these changes beforehand.

In the event my account is not paid, that it may be sent to a collections agency. If so, I agree to pay all costs of the agency, including but not limited to, reasonable attorney fees if applicable.

Creekside Dental requests **2 BUSINESS DAYS' notice for all cancellations** and that without such notice there will be a fee of $50 placed on my account, which is to be paid before my next appointment can be scheduled.

Treatment that is required is not always the same as treatment that is covered by my insurance plan. All treatment being suggested by the dental health practitioners at Creekside Dental is being done so with my dental health in mind.

I am expected to be on time for all my appointments and should expect the same from the dental health practitioners at Creekside Dental. However, I am also aware that sometimes unforeseen emergencies do come up and may interrupt the regular schedule of appointments.

I am responsible for my insurance coverage. This includes providing correct and current information related to my plan in order to submit claims accurately. **Creekside Dental is not aware of my dental coverage details unless I have provided it to them. Any inquires about my insurance plan need to be directly directed by me.**

*If there any further questions about our office policy, please ask our receptionists prior to signing this form.

____ ____________________
Responsible Party Signature Date Signed

____
Best method of contact (mobile,home # or email)