Beachcrest Dental, Inc.
88 Beach Street
Westerly, RI 02891

FINANCIAL RESPONSIBILITIES OF PATIENT

1. I understand that I am financially responsible for all services rendered **at the time of service** or within 30 days of billing (when my copay amount cannot be determined in advance), for all services rendered by Beachcrest Dental, Inc.

2. **At every office visit**, I will present my most recent **insurance card** that contains accurate and up to date insurance information, so that we may scan for my file.

3. **Broken appointment fee**. I understand that your office requires at least 24 hours advance notice for canceling or rescheduling an appointment. For Monday appointments, I understand that I need to cancel or reschedule by 12:00 Noon on Thursday. If I fail to give the required notice, then a broken appointment fee of $55 will be charged.

4. I understand that Beachcrest Dental will bill my insurance company and that I am responsible for the copay, deductible and any co-insurance non covered services (at the time of the visit if my copay amount has been pre determined).

5. I understand if I do not have health insurance, then I am responsible for payment in full upon completion of the visit.

6. Past due accounts will be subject to collection and attorney cost and fees.

I have read and understood the above policies and obligations, and agree to them for all office visits, including future appointments.

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Patient's Name (Please print)

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Signature of Patient (or Parent/Guardian) Date