Name: _____

Douglas M Adel D.D.S., P.A.
14211 NW 150th Ave
Alachua, Fl 32615
386-462-4635

OFFICE POLICY

I. DENTAL INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to Dr Douglas M Adel for examinations or treatment of any dental benefits herein specified and otherwise payable to me for their services as described.

2. RESPONSIBILITY FOR PAYMENT –I agree that if a service is rendered to me I will pay this amount unless other arrangements are made ahead of time. I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference in accordance with the agreement between Dr Douglas M Adel and my insurance carrier. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy.

3. LATE FEES - I understand that payment for professional services is due when said services are rendered unless other arrangements are made in advance. I agree to pay all amounts not payable by insurance immediately when billed. All amounts not paid within 60 days of the billing date may be assessed monthly late fees in the amount of 1.50 % of the outstanding balance. I understand if the balance amount due is not paid that my account will be sent to collections.

4. **CANCELLATION POLICY-** We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of January 1, 2014 there will be a fee of $50.00 assessed if we do not receive a call to cancel an appointment. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Signature of patient

_____Date_____