MICHAEL J. SELLECK DDS, DABDSM
935 MORAGA RD., SUITE 101
LAFAYETTE, CA 94549

FINANCIAL RESPONSIBILITY & CANCELLATION POLICY

FINANCIAL AGREEMENT

Thank you for choosing Renaissance Dental Group! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our guests as possible by offering several payment options.

PAYMENT OPTIONS:

- Cash, Check, Visa, MasterCard, American Express, or Discover Card.
- Special Financing options with convenient monthly payments with CareCredit, or
- In-house Financing

COURTESY OPTIONS:

- For our senior guests (age 65+) who pay for their visit on the day of service, we extend to you a 5% senior credit.
- For our cash paying guests, it is our pleasure to extend to you a 5% courtesy on amounts over $300 if paid in full the day of service.

I acknowledge and agree that I am responsible for and will pay for all regular charges which are contained in the applicable dental procedure provided by *Renaissance Dental Group*. I agree to pay for all regular charges incurred on the dates of service(s) rendered for items and/or services provided to Patient, including any amount not paid by my insurance plan for their treatment.

I understand that I am personally responsible for any item or service determined by my third party payor (my dental insurance company) to be experimental, investigational or to be non-covered for any other reason.

CANCELLATION POLICY

I understand that if I need to change an appointment, I must give **at least 48-BUSINESS HOURS NOTICE** to *Renaissance Dental Group* prior to my scheduled appointment. Please be advised that a cancellation with less than **48-BUSINESS HOURS NOTICE** will result to an **$85.00 charge**.

If rescheduling and cancellations become chronic (more than 3 missed appointments) we will require that each future appointment be reserved with a credit card for the total amount for that appointment.

I have read the above information, understand and consent to the financial agreement and cancellation policy.

Patient Name **Patient/Legal Guardian Signature** **Date**

Thank you for your assistance in complying with our policy.