Kendall Square Dental Associates
Office Policy

Patient Name:

FINANCIAL AGREEMENT:

All estimated co-payments are expected at the time services are rendered. As a courtesy to you, we will submit completed procedures to your insurance company. Insurance is only designated to cover a portion of customary fees, therefore you are responsible for any remaining balance. **Please make note that all outstanding balances will be subject to an 18% annual finance charge.**

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize direct payment of dental insurance benefits to Kendall Square Dental Associates for treatment rendered to myself and/or my child/children.

CANCELLATION AND FAILURE TO ARRIVE:

We require a 24 hour cancellation notice for all scheduled appointments. Occasionally circumstances do arise that may keep you from attending your dental appointment. **A fee of up to $50.00 per hour may be applied if not given adequate notice.**

RADIOGRAPHS:

Original radiographs are the property of Kendall Square Dental Associates. If you wish to obtain a copy, we require 24 hours notice and will charge from **$5.00 to $15.00** dollar duplication fee.

I have read and agree to the above policy.

Patient/Parent _____ **Date:** _____