

**James A. Richardson, DMD**  
**Margaret H. Lunn, DMD**

**Financial Policy**

This office makes every effort to work with our patients on financial matters. If you have dental insurance we will gladly file it for you. However, the agreement with your insurance company is between you and your insurance company. We may estimate the portion they will pay toward your dental treatment, but it is only an estimate. You are ultimately responsible for your account. We will ask that you pay your deductible and estimated portion of your treatment fee at the time of service. If you do not have dental insurance, we request payment in full at time of service unless other arrangements are made in advance and in writing.

I have read and understand the above policy. I am responsible for this account.

Patient or responsible party: \_\_\_\_\_

Date: \_\_\_\_\_

**Attendance Policy**

We understand, on occasion, cancellations are necessary. Please remember that each appointment time is reserved exclusively for the individual patient, and without adequate time to fill the broken appointment, the operator is empty for that time. Unfortunately, the overhead for the operator continues. Therefore, if we are unable to have 24 hours notice of a cancellation, a fee may be assessed to your account. We would prefer to never make that charge. Please arrange your schedule to keep your appointments.

I hereby acknowledge that I have read and understand the above paragraph.

Signed \_\_\_\_\_ Date \_\_\_\_\_