OFFICE POLICY

We want to thank you for allowing our office the opportunity to participate in your oral health. We take great pride in our office and feel that it is our mission to render the finest surgical services to our patients.

In order for our newly formed relationship to be mutually satisfying and beneficial, we ask that anytime you have a question or concern with your treatment (proposed or performed), fee for service, or attitude about our staff, that you will discuss it with us promptly and openly. Misunderstandings and lack of communication are the only obstacles to our continued professional relationship.

If you are unable to keep an appointment, we ask that you kindly provide us with at least 24 hour notice. This courtesy on your part will make it possible to give your appointment to another patient.

FINANCIAL POLICY

We respectfully request that payment be made on the date of service. Forms of payment accepted by the office are check, cash, Visa and MasterCard. Fees are subject to change with prior notice before treatment. There is a $25 processing fee for returned checks. For our patients with the benefit of insurance coverage your estimated patient portion is due on the date of service. The estimated insurance portion is not a guarantee of payment. It is the patient's responsibility to understand their insurance policy prior to treatment. As a courtesy to you, our office will complete and submit insurance forms for services rendered to your insurance company. In the event that your insurance company does not pay in whole or in part for any reason, you will be responsible for the remaining balance. **Please be advised that Dr. Beau McKenzie Soares is not a Medicare, TriCare or other government healthcare provider. Therefore, there will be no billing sent to Medicare and/or supplemental insurance for reimbursement.** I take responsibility for payment of all services rendered on my behalf, my dependents including my dependants over eighteen years of age regardless of insurance involvement.

_____ _____

Patient/Responsible Party Signature Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION RELEASE

I hereby authorize my insurance company to pay Beau McKenzie Soares, DDS., Inc. benefits accruing to me under my dental / medical insurance policy for services rendered. I understand I am financially responsible to Dr. Soares for charges not covered by this assignment. I hereby authorize my doctor to release any and all information to my dental / medical insurance company which may be requested regarding my treatment.

_____ _____

Patient/Responsible Party Signature Date