WELCOME TO OUR OFFICE
HAROLD S.SPEIGHT, D.D.S., P.A.
General Dentistry

Thank you for choosing our office for your dental care. We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.

Financial Agreement

- I understand that payment for services is completely my responsibility.
- I understand that my insurance is an agreement between the insurance company and me and not between Dr. Speight and the insurance company. (We file the insurance as a courtesy.)
- I must provide the following information for this office to accept insurance as payment.
  Current Dental insurance information and/or insurance card;
  Complete dental insurance form if I need help filing my secondary insurance.
  If insurance can not be verified or if I do not have insurance, I will pay in full with cash, check or credit card at the time of service. I understand that Dr. Speight's office gladly accepts **American Express, Discover, Master Card, Visa and Care Credit.**
- I also understand that I am responsible for any balance over 60 days from the claim date.
- I understand that if for any reason my account is turned over to a collection agency, I will be responsible for any and all fees to collect my balance.

Appointments: In order to give the most efficient care, we work with an appointment system. Our appointment hours are Monday 10am-7pm (Closed for lunch 2-3pm), Tuesday-Thursday 8:30am-5:30pm (Closed for lunch 1-2pm) and Friday 8:30am-1pm. We make every effort to honor all time commitments and ask that the patients extend the same courtesy. We aim to give you all the time and attention you need while in our office. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. We are available when emergencies arise and will do our best to give prompt consideration as needed.

Cancellation Policy: I understand that, if I am unable to keep my scheduled appointment, I will notify the office at least twenty-four (24) hours in advance of my scheduled appointment time. Please note schedule changes will be accepted only during regular office hours. I am aware that I may be charged a **$25.00 fee** if I do not provide twenty-four (24) hours notice for cancellation or do not show up for the appointment. If you fail to show up for three (3) appointments, we may not be able to schedule you for anymore appointments.

Parents: We provide children with the same attentive care that our adult patients receive and prefer to care for them as individuals. Parents may accompany children in the operatories as long as their presence is helpful. We do ask that you remain in the building or in close contact with us while minor children (under 18 years of age) are being treated in our office.

I CERTIFY THAT I HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

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Patients Name (Please Print) **Patient Signature or Guardian**

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Date