OFFICE POLICY

A FINANCE charge of %1.5 will be added to all accounts past due 60 DAYS and a late fee of $17.00 will be added for each additional statement sent. Any account turned over to a collection agency or an attorney will be YOUR RESPONSIBILITY for any collection fees, attorneys and any court costs. A service charge for returned checks will be added to the account in the amount of $35.00 for each occurrence!

Time is valuable for both you and I. PLEASE notify us within 24 hours prior to the appointment if you must cancel. FAILURE TO DO SO WILL RESULT IN A CHARGE OF $45.00 . This fee ALSO applies to NOT SHOWING up for your appointment.
We will file primary insurance as a courtesy to you. You will need to pay your co-payment on the day services are rendered. You will be responsible for filing secondary insurance if you have it. The insurance form we give you will assist you in filing.

Date:_____

Patient:_____

Employer:_____

SSN/Group number:_____

I hereby instruct and direct my insurance company to pay Dr. Myles Williams by check. If my current policy prohibits direct payment to Dr. Myles Williams, I hereby instruct and direct myself to make out the check to Dr. Myles Williams.

PARENTS: Please inform the front office personnel if you have to leave the office while your child is undergoing dental treatment!

Signature of Policyholder or Guardian:_____