MISSED APPOINTMENT FEE: Our office hours are Monday through Friday, with appointments made exclusively for each patient. We recognize the value of your time. Except in the case of an emergency, you can expect us to be on time. We would appreciate the same courtesy. If for some reason you cannot make your appointment, we ask you to notify us 24 hours in advance. If you are not present on time for an appointment, or cancel with less than 24 hours notice, there will be a missed appointment fee. The charge will vary depending upon the amount of time scheduled for the missed appointment.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect on this debt. If we turn your account over to the court, you agree to pay all the court fees which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney's fees which we incur along with court costs. In case of suit, you agree the venue shall be in Gaston County, North Carolina.

WAIVER OF CONFIDENTIALITY: You understand that if this account is submitted to an attorney or the court, the fact that you have received treatment at our office may become part of public record.

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect for the other parent.

TRANSFERRING RECORDS: You will need to request in writing, and pay a reasonable fee (currently $23) if you want copies of records sent to another doctor. You must authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor to us to receive all relevant information, including your payment history.

CONSENT FOR TREATMENT: I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs and any other diagnostic aid deemed appropriate by the doctor to make a diagnosis of my and or my dependents dental needs. Upon such diagnosis, I authorize the doctor and designated staff to perform all recommended treatment to provide proper care for myself or my dependents. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks.

TREATMENT OF CHILDREN AND MINORS: WE require a parent or legal guardian to accompany a minor child to their dental visit and to remain in the reception room throughout the course of their treatment. This insures the ability to communicate with the parent or guardian, while allowing us to develop a one on one relationship of trust and cooperation with the child.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.