Dear Patient,

The Doctors and Staff would like to take this time and welcome you to our practice. We are happy that you have chosen our office for all your smile care needs. We strive to give the quality dental care that you deserve and are committed to achieve patient satisfaction.

As a Galt Healthy Smile patient we would like to go over some of our policies before you are seen.

- **On time arrival is an important factor in our office. Your appointment time is scheduled especially for you. Any change in the schedule affects many people. If you are 15 minutes late for your appointment we may limit the treatment for that day or reschedule for another day.**
- **24 hour notice is required for any change or cancelation of appointments. <u>There is a $25.00 charge for any failed appointments or cancelations with less than 24 hours notice.</u>**
- **Payment is expected at the time of service unless other payment arrangements have been made.**
- **We have a $25.00 fee for all returned checks.**
- **Having insurance does not guarantee payment. Benefits are determined by your insurance company not by our office. Any co-pays presented to you are an estimate not a guarantee. <u>You are responsible for any balance on your account.</u>**

I understand the office policies and acknowledge that they have been explained to me.

____ _______________________

Patient/Responsible Party Signature Date

216 N. Lincoln Way, Suite #40, Galt CA 95632 (209)744-9955