

Joseph Passamano, D.D.S.
www.MydentistJoe.com

OFFICE POLICY AND PROCEDURES

Thank you for choosing Dr. Passamano as your family provider. When scheduling your appointments, we are making a commitment and reserved a time for you. If you need to reschedule your appointment, please give us a minimum of 48 hours notice or will be subject to \$50 charge.

Return checks are subject to a \$35 charge. This fee is to cover our bank charges. Please let us know if special financial arrangement needs to be made.

Patient portion is due at time of service. Please bring your co-payment with you.

We bill your insurance as a courtesy to you. If any amounts are denied or not covered, the balance owing is your responsibility. Your estimated patient portion is based on the information provided by your insurance company, and is due when services are rendered. Please ask for an estimate if one has not been given to you.

We are unable to provide adequate supervision of children. Please refrain from bringing unattended/unscheduled children to your appointment.

Patient acknowledges in consideration for dental services, any outstanding debt to our office will not be included in any bankruptcy petition.

Patient acknowledges that a copy of the Privacy Notice is available from our office. By signing below, patient acknowledges that he/she does not wish to obtain a copy now but reserve the right to get a copy at anytime. The Privacy Notice describes the types of uses and disclosures of protected health information that might occur in treatment, payment for services, or in the performance of office dental care operations.

Signature of Patient or Responsible Party

Print Your Name

Date