NOTICE TO ALL PATIENTS OF OFFICE POLICY

Gordon A. Bech, DDS
925 Cross Gates Blvd.
Slidell, LA 70461
985-641-4180

Please read and initial each item, then sign and date at the bottom:

_____ 1. I understand that office policy states that a **$50 missed/broken appointment fee** will be applied to any appointment that is missed, broken or cancelled less than 24 hours prior to the scheduled appointment time.

_____ 2. I understnad that if I carry a secondary or supplemental dental insurance plan, that I am solely responsible for filing and acceptance of payments from those plans. **Dr. Bech or his staff will NOT file the secondary or supplemental dental insurance**. In the event that payment is issued to Dr. Bech, a refund will be issued.

_____ 3. I understand that **Dr. Bech will not file any medical insurance of workmen's compensation policy or claim**. Any claim that may need to be filed with either of these entities will be the sole responsibility of the patient. All procedures performed as a result of a medical or workmen's compensation claim will need to be paid in full at a time of service.

_____ 4. I understnad that **any returned checks will be assessed a $25 NSF fee** and that future appointments will need to be paid in cash or with Visa or MasterCard.

_____ 5. I understand that if I am unwilling to give pertinent personal information (i.e social security number, insurance identification number) to be used for the sole purpose of filing for payment from my insurance provider that I will be responsible for cash only, payment in full prior to being seen by Dr. Bech or staff. If I refuse either option, I understand that I will be seen.

_____ 6. I understand that if I am unwilling to provide a current or updated medical history including medications I am taking, that is the right of Dr. Bech and/or staff to refuse treatment until this information can be provided.

Patient: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____