To My Valued Patient,

I have a purpose - and that is to help every patient achieve optimal dental health. I have a competent, cohesive team to aid in this mission. A commitment on your part is also necessary to attain the goal of dental health. Therefore, I would like to take this opportunity to explain our office procedures which must be agreed upon in order for us to have a successful, long term Doctor-patient relationship.

APPOINTMENTS: We make every effort to reserve an appointment of your choice. As a courtesy we call to confirm your appointment a few days prior to your visit. Failure to keep a scheduled appointment causes setbacks in care and compromises the health of your teeth and gums. A broken appointment also prevents other patients from receiving necessary care and increases costs for everyone. We will need 48 hours notification of unavoidable cancellations. A $25 fee will be applied to all broken appointments with less than 48 hours notice.
Your promptness is appreciated. We pride ourselves on seeing patients on time. In order not to compromise your, or the next patient's care, if you are more than 10 minutes late you may be asked to reschedule your visit. __________initials

INSURANCE: Our office makes the very best treatment recommendations for your overall dental health regardless of insurance coverage (or lack thereof). Unfortunately, insurance companies are not concerned about your health, we are! Your dental insurance plan may not cover the full cost of the specific treatment you require. Insurance policies can be very complex and it is impossible for our office to know each specific plan and their respective limitations. Therefore, it is your responsibility to be familiar with your dental benefits and to inform our office if there have been any changes to your coverage. As a courtesy, we will electronically submit all claims with the necessary documentation to your primary and secondary carriers to aid in reimbursement. In the event your insurance company does not satisfy your claim within 60 days you will be billed. All fees for treatment not covered by your insurance plan are ultimately your responsibility. __________initials

PAYMENTS: We are a zero balance office. If you do not have dental insurance then payment in full is due prior to or at the time treatment is provided. For your convenience we accept cash, checks, Visa, MasterCard, Discover, and Amex. We also offer outside financing through Care Credit. ________initials

UPSETS: It is my goal to ensure complete satisfaction of all our patients. However, it is possible on occasion that there may be a misunderstanding between you and our office. Should an upset occur, we will make it right provided you bring it to our attention in an appropriate, cordial manner at a time that we can give the matter the proper attention it deserves for effective resolution. Please see Lisa, our office manager to resolve any upsets you may have. __________initials

I believe that through mutual understanding and agreement of the above office guidelines, my team and I will be able to concentrate on providing you with the highest standard of care and service.
Thank you for entrusting your smile to us!!
Most Sincerely Yours, Dr. LaFalce

I_________________have read and reviewed the above with _____________________.
(Print name) (Team member)

Signed ____________________________________ Date________________