



Office Policy

Thank you for choosing **McRae Dental Associates** as your dental health care provider. We are committed to building a successful doctor/patient relationship with you and your family. Your clear understanding of our patients' financial responsibility is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions regarding our fees, office policies or your responsibilities. It is your responsibility to notify our office of any patient information changes (medical history, address, phone number, insurance information, etc.).

I understand that all co-pays and account balances must be paid prior to receiving dental treatment. A finance charge of 1.5% will be added to all accounts past due of 30 days. Any account turned over to a collection agency or an attorney will be **your responsibility** for any collection fees, attorney fees and any court cost. A service charge for returned checks will be added to your account in the amount of **\$35** for each occurrence.

Time is valuable for both you and I. Please notify us within **24 hours** prior to the appointment if there are any changes. Failure to do so will result in a charge of **\$25**. This fee also applies to not showing up for a scheduled appointment.

Parents: Please inform the front office personnel if you have to leave your child while he/she is receiving dental treatment. If your child has to accompany you to your dental appointment, and are not being seen by the dentist as well, he/she cannot be disruptive in the waiting area.

Patient name

Date

Signature of Patient, Parent/Guardian: