HARBORSIDE
DENTAL ASSOCIATES

Office Guidelines

We welcome and appreciate the opportunity to provide for your dental needs. We do our best to provide you with superior dental and patient care. Please read this document thoroughly and sign at the bottom to acknowledge that you have read and understand this document.

Financial Guidelines: We provide a complimentary insurance benefit check for patients with dental insurance coverage to help you better understand your plan. We will estimate, as closely as possible, what portion your insurance will cover. Patients without insurance are expected to pay in full by cash, check, or major credit cards on the day services are rendered. We also offer CareCredit—please feel free to ask a team member about this service.

Appointments: We make every effort to provide dental care in a timely manner. We understand your time is valuable and want your visit to be as convenient as possible. To provide the most efficient care, we work within an appointment system and reserve your appointment time specifically for you. We do our best to honor all time commitments and ask that patients extend the same courtesy. We aim to give you the time and attention you deserve during your visit. Please help us achieve this by arriving on time. If you are more than 15 minutes late, we may need to reschedule your appointment to ensure enough time for treatment.

Cancellation Policy: I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least forty-eight (48) hours in advance. I understand that I must call the office to confirm my appointment within forty-eight (48) hours. If I do not call to confirm, my appointment may be released to another patient. Please note that schedule changes will only be accepted during regular office hours. I am aware that I may be charged a fee if I fail to provide forty-eight (48) hours' notice of cancellation or do not show up for the appointment. The fee will vary depending on the length of the scheduled visit and will not be less than $45. If I fail to show up for two (2) appointments, I may no longer be eligible for scheduling and could be dismissed from the practice.

If you understand and agree to the above guidelines for our office, please sign below:

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, describe your relationship to the patient:

_____ _____

Relationship Printed Name