WELCOME TO BAYVIEW DENTAL & IMPLANT CENTRE
New Patient Agreement

I, _____, understand that:

The financial policy of this clinic is to pay at the time that services are rendered.

I am responsible for all the fees incurred for my own treatment and/or for the treatment of a minor/dependant that I am responsible for, **regardless of insurance coverage**.

That as treatment progresses, fees may have to be adjusted, but I will be informed of these adjustments.

BayView Dental & Implant Centre requests **2 business days' notice for all cancellations** and that without such notice there will be a fee of $50 placed in my account, which is to be paid before my next appointment can be made.

Treatment that is required is not always the same as treatment that is covered by my insurance plan. All treatment being suggested by the dental health practitioners at BayView Dental is being done so with my dental health in mind.

I am expected to be on time for all my appointments and should expect the same from the dental health practitioners at BayView Dental. However, I am also aware that sometimes unforeseen emergencies do come up and may interrupt the regular schedule of appointments.

I am responsible for my insurance coverage. This includes giving the dental office the correct and current information related to my plan in order to submit claims accurately.

BayView Dental & Implant Centre is not aware of my dental coverage details unless I have provided it to them. Any inquiries about my insurance plan need to be directly directed by me.

* If there are any further questions about our policy, please ask our receptionists prior to signing this form.

_____ _____

Responsible Party Signature Date Signed