MYSTIC DENTAL GROUP
A PROFESSIONAL CORPORATION

OFFICE POLICIES & FINANCIAL AGREEMENT

Welcome to MYSTIC DENTAL GROUP! We are honored that you have chosen us as your dental healthcare provider. We are committed to providing you with the highest quality of care in a pleasant and comfortable environment.

Patients without Dental Insurance: Payment in full is required at the time services are rendered.

Payments Options: Cash/Check/Visa/MasterCard/Amex/Discover/Care Credit

Past Due Accounts: Account aging begins the day your charges are incurred. Accounts that are ninety days past due may be turned over to a third-party collection agency. Should it become necessary to place your account for Collections, and/or Small Claims Court, you shall be responsible to pay all costs thereof including, but not limited to, attorney fees. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will provide emergency referral for a period of 30 days.

Cancellations: Our goal is to have a relationship of trust and respect with our patients. We require a 48-hr. notice to cancel an appointment. Habitual "NO SHOWS" or "CANCELLATIONS" may result in the ability to schedule future appointments. Please mark your reserved appointment day and time on your calendar. We look forward to seeing you.

Minors: The adult accompanying a minor is responsible for full payment of services. Please do not leave children unattended. Divorce decrees are between the two consenting adults, and we are not responsible for separate billing.

Mystic Dental Group reserves the right to update and make changes to the above stated policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered for me and my dependents (if applicable).

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patients' s dental needs.

3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk, Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1% finance charge maybe added to my account, in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
7. I authorize the use of my social security number to file my dental claim.

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Patient's signature (parent if minor) Date

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Patient's Name (please print)