DULUTH DENTAL CENTER CANCELLATION POLICY

We strive to be on time and expect the same from our patients. A minimum of 48 hour notice is **REQUIRED** to cancel or reschedule appointments. A $75.00 charge will be applied to your account for no shows and failure to cancel within 48 hours. If you are more than 15 minutes late for your appointment we cannot guarantee that you will be seen.

Patient's Signature_____**Date**_____

CONSENT FOR TREATMENT

I hereby authorize Dr. Shifrin or designated staff to take X-Rays, study models, photographs and other diagnostic aids deemed appropriate by the Doctor to make thorough diagnosis of dental needs. Upon such diagnosis, I authorize Dr. Shifrin to perform all recommended treatment mutually agreed upon by me and the employ such assistance as required to provide proper care. I agree to the use of anesthetics and other medications as necessary, I fully understand that using anesthetic agents embodies certain risks and for a complete recital of any possible complications

Patient's Signature_____**Date**_____

FINANCIAL RESPONSIBILITY

I agree to be responsible for payment of services rendered on my behalf or my dependents. I understand that **payment is due at the time service** unless previous arrangements have been made. I understand that even if I have insurance, the agreement is between Dr. Shifrin and myself, NOT the insurance company, and I am responsible for and balance remaining after Insurance has paid. Should your account become 90 days **PAST DUE**, the account may be turned over to collections and you will be responsible for the balance, along with any fees incurred (such as collection fees, court cost or attorney fees).

Patient's Signature_____ **Date** _____