DREW HINES, D.M.D.
319 S. SHARON AMITY
SUITE 102
CHARLOTTE, NORTH CAROLINA 28211
704-366-3526
charlottedentalsmiles.com

Patient Financial Responsibility Agreement

I agree in return for services provided by Drew Hines DMD that I will **pay my account at the time services are rendered, unless prior arrangements are made**. We may or may not participate with your dental plan. We will submit any claims to your dental plan, but you will be responsible for any remaining balance for services rendered.

It is important for you to understand that your procedure(s) may or may not be reimbursable by your insurance depending on your plan. We are here to help so if you have any question please let us know.

By signing you authorize Drew Hines, DMD to bill your insurance company for services rendered.

Patient Name *please print:* _____

Patient or Guarantor signature: _____ **Date:** _____

Cancellation and No Show Policy

We understand that situations arise in which you can't make your scheduled appointment, and we ask that you provide us with **at least 48 hours notice to cancel or change the appointment**. By doing so, we can offer your time to another patient who is waiting to receive services. The lack of adequate notice is considered a no show, as we are unable to use you appointment slot for another patient.

No show and cancellations with less than 48 hours notice may be subject to a $50 cancellation fee. Patients who do not show or give inadequate notice two (2) or more times may be dismissed from the practice. Cancellation fees are the sole responsibility of the patient and must be paid in full before the next appointment.

We understand that special unavoidable circumstances may cause you to miss your appointment or give inadequate notice. If this happens please let us know as far in advance as possible. Cancellation fees in this instance may be waived.

Our practice believes that a positive doctor/patient relationship is based upon understanding, good communication, and mutual respect. If you have questions about our no show and cancellation policy, please ask.

Patient Name *please print:* _____

Patient or Guarantor signature: _____ **Date:** _____