Robert M. Reid, DDS
130 Oxford Road
Fern Park, FL 32730
(407)831-1819

FINANCIAL POLICY

NO SHOW/ CANCELLATION POLICY

You will be charged a **$25.00** fee for missed appointments or appointments not cancelled with a 24 hour notice. This fee must be paid prior to any future appointments.

AUTHORIZATION AND RELEASE

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal check, care credit, and all major credit cards.

To the best of my knowledge, Section 1,2,3,4, & 5 are complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with
and assign directly to **Dr. Reid**. All insurance benefits, if any otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or four years from the date signed below.

Patient Signature (parent/guardian) ______________________ Date ______________