

Cutbirth & Sanderson, D.D.S.  
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Magnolia, Texas 77355  
(281) 356-3721

## OFFICE POLICY

Thank you for entrusting us with your dental care. As a team we strive to provide the highest quality care in a friendly relaxed atmosphere. We would like to take this time to make you familiar with some of our policies. **Please read and initial next to each statement.**

FULL PAYMENT IS DUE AT THE TIME OF SERVICE  
WE ACCEPT CASH, CHECKS, MAJOR CREDIT CARDS, AND MOST INSURANCE

\_\_\_\_\_ Our office will file your insurance as a courtesy to you, but if for any reason your insurance company does not pay within 30 days from the date of service, **please understand that you will be responsible for the unpaid balance.**

\_\_\_\_\_ We do not double book our patients, therefore we have a strict cancellation policy.  
- Appointments under 2 hours- we require **24 business hours'** notice.  
- Appointments 2 hours in length and longer – we require **48 business hours'** notice.  
Please help us serve you better by keeping scheduled appointments.

\_\_\_\_\_ Adult patients are responsible for payment at the time of service, unless previous arrangements concerning that day's treatment have been made.

\_\_\_\_\_ The adult accompanying a minor patient is responsible for full payment at the time of service. Arrangements should be made for unaccompanied minors to pay at the time of service.

\_\_\_\_\_ Please be on time. This allows us to see all of our patients in a timely manner. When patients are 10-15 minutes late we would rather reschedule the appointment than hurry through the needed treatment or run into the next patient's scheduled time.

**It is our policy to give you our undivided attention during your appointment. Unless we are treating an emergency, we do not double-book like other practices, so the cost of needlessly missed appointments is especially expensive to us all - in overhead, time and eventually, in patient fees.**

**Thank you for your understanding and cooperation.**

**Print name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_