



1328 W. El Camino Real, Mountain View CA 94040. Tel. (650) 962-8773 Fax. (650) 962-8464

*Your family Dentist*

## **INFORMATION REGARDING OUR PRACTICE**

**APPOINTMENTS:** We recognize the value of your time. We will do our very best to see you as promptly as possible. If there are any delays in your appointed time, our team will let you know right away. It is important that you come to your appointment 15 minutes before your scheduled time to register. If your schedule requires that you must leave your appointment at a certain time, please make sure to communicate that and we will do our very best to make that happen.

### **YOUR VISITS WILL INCLUDE YOUR OPTIONS FOR:**

- ◆ Quality time with Doctor & staff
- ◆ Visual tour of your mouth
- ◆ Optimal dental treatment with the latest techniques and materials
- ◆ Sterilization Methods of the highest standard
- ◆ Treatment estimates given in writing before treatment

**OUR GUARANTEE:** We are proud of our work. We give a guarantee on treatment received in our office. We extend this guarantee to our patients who complete all recommended treatment and keep all recommended hygiene and restorative appointments.

**EMERGENCIES:** Dental emergencies occur from time to time. When they do occur, please call our office immediately. We are equipped to take all before and after normal business hours phone calls and return your call as soon as possible.

**DENTAL INSURANCE:** We are happy to file the forms necessary to see that you receive the optimal benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all of our patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits.

**CANCELLATIONS OR BROKEN APPOINTMENTS:** We are able to extend a “no charge” fee to our patients who give us 48 working hours notice if unable to keep the scheduled appointment. A charge of \$50 will be made per patient per hour for each appointment that is not kept or not given adequate notice. *Thank you for your cooperation.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_