Office Policy

Because we want to provide the highest quality of treatment, we ask that you respect our time as well as your fellow patients by following a few simple rules:

(Please initial on each line and sign at the bottom)

____ Please be on time or early for your scheduled appointment so other patients appointments are not affected.

____ If you are more than 15 minutes late for your appointment, we may require you to reschedule to another time.

____ We ask that you please turn your cell phones off or to vibrate mode during your treatment. In case of emergency, you may go to the waiting area or outside the office building to take the call.

____ We must be notified if you are unable to make your appointment 48 hours prior to it.

____ If you do not call to cancel your appointment (no-show) for two consecutive visits, we will remove your name from the schedule for any future appointments. You must call and speak with Dr. Griesser before being placed back on our schedule.

____ If our office cannot contact you within one week or if you do not call back within one week from your missed appointment, you can and may be discharged from treatment.

____ All missed appointments without proper notification to the office will be charged $83.00.

Payment Policy

In order to maintain high quality standards in dentistry, Please be aware that: Payment is expected at the time services are rendered. As a courtesy, we, will gladly process your claim, however we request that you pay your estimated portion when services are rendered. If payment received from your insurance company is less than we estimated, or your estimated insurance payment do not equal the total fee, you will be responsible for amount remaining on your balance. Should this occur, a statement will be mailed to you. We understand that insurance can be very confusing. We would like to answer any questions you may have before treatment begins to assure that you are as comfortable with your finances as you are with your dental care.

Signature: _____ Date: _____

In the event it's determined that the insurance was not in effect at the time services were performed, I understand that I will be responsible for all the charges. By signing below, I understand and agree to the terms listed above. If you have any questions please don't hesitate to ask Dr.Griesser or a staff member. Thank you for your continued confidence.

Signature: _____ Date: _____