BAY COSMETIC DENTISTRY
JEFFREY V. SCHROEDER, D.D.S.
RICHARD P. SABLE, D.D.S.
MICHAEL R. SCHER, D.D.S.

WELCOME TO OUR OFFICE

Thank you for choosing our office to help serve your dental needs.

Our goal is to provide you with excellent care, service, and a better understanding of our procedures from our dedicated staff. We want to make you feel comfortable. To make sure all dental claims are processed correctly and monthly billing statements are accurate, we need your help in maintaining updates to your dental records.

Please inform us of any change in address, phone numbers, insurance or employment at least 48 hours prior to your appointment. By providing up to date information, we will be able to prevent claims from being delayed. As a Preferred Provider, please understand that the patient is responsible for the portion of the bill not covered by Insurance at the time of service. Payment is due the time services are rendered unless prior arrangements are made.

If you need to cancel an appointment please do so 48 hours prior to your appointment time. Failure to do so will result in a $50 cancellation fee being assessed to your account.

☐ Initial here to acknowledge understanding & acceptance of the cancellation policy.

If your treatment entails a long appointment time, you may be required to pay a deposit prior to that appointment. If you have any questions about your bill, or any other concerns, please feel free to speak to the office manager.

Thank you!

I have read and understood the office policies listed above, I will be provided with a copy upon request.

Signature of patient (or parent/guardian if minor) _____ Date _____

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