premierdentistry
TEL: 300-3221/3222 • PREMIERDENTISTRYGUAM.COM
692 N. MARINE CORPS DR. STE 301 UPPER TUMON, GU 96913

Premier Dentistry Clinic Policies (updated 2021)

Broken Appointment Policy: I understand broken appointments are both costly and inconsiderate. If for some reason, I am unable to keep my appointment, I am aware that I must contact Premier Dentistry **at least 48 hours in advance (for surgeries) and 24 hours in advance (for all other appointments).** I understand that reminder calls are made as a courtesy and that it is my responsibility to keep track of my appointment or to re-schedule in a timely manner. I acknowledge that there is a **$100.00 broken appointment fee** (for surgery-related appointments) and a **$50.00 broken appointment fee** (for all other procedures), and that the fee will automatically be charged to my account. I understand that the fee must be paid BEFORE I will be permitted to re-schedule. I further acknowledge that if I fail to keep my appointment a second time, the fees will double; and if a third broken appointment occurs, I will no longer be accepted as a patient at Premier Dentistry. **Initial: _____**

Financial Agreement Policy: I acknowledge that **payment is due at the time of treatment** and that there are no extended payment plans. In the case of minor patients, I agree that as parents/ guardians, I am responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges to my account, and for the account(s) of my dependent child(ren). Methods of payment include cash and credit card such as Visa, Mastercard, or Discover. Personal checks are not accepted. **Initial: _____**

Credit Card Refunds: For credit card refunds not caused by an error on the part of Premier Dentistry, I acknowledge that a 3% credit card transaction fee will be deducted from the refunded amount. **Initial: _____**

Privacy Policy Acknowledgement: I have received and reviewed the Notice of Privacy Practices and accept the contents of the Notification. **Initial: _____**

Minor/ Child Consent Policy: I, the parent/ guardian of _____ do hereby authorize the dental staff of Premier Dentistry to perform all necessary dental services for my child, including but not limited to, x-rays, administration of anesthetics, full dental treatment plan, per the doctor's recommendations. I understand that patients under 18 years of age MUST be accompanied by a parent or legal guardian, and that the parent/guardian must remain in the clinic from the start of treatment to its completion. I understand that if I cannot be present during my child's dental appointment, I must provide written authorization to an adult who will accompany my child. **Initial: _____**

Child Supervision: Children under 18 years of age **must be supervised by an adult at all times**. Children may not be left alone in the waiting area, unattended; nor may children (who are not patients) enter the treatment area. A parent or guardian who are undergoing treatment may not bring children to sit with them in treatment rooms. The clinic does not offer babysitting services. Please make other supervisory arrangements for your child(ren). **Initial: _____**

I acknowledge that I have read the above information and accept its contents.

_____ _____

Print Name of Patient/ Parent or Guardian Date

_____

Signature of Patient/Parent or Guardian