

**Patient & Office Agreement  
Commitment, Dental Insurance,  
& Financial Obligation**

**Restorative Dental**

George Bare Jr, DMD  
237 Dunbar Cave Road  
Suite A  
Clarksville, TN 37043  
931-648-0604

**Our Vision & Commitment to You:**

We have a vision to provide you with the highest level of quality care. We are committed to recommending and diagnosing only the type of dentistry that we would extend to our own family. We promise to provide you with the facts and a treatment plan based on your smile and oral health needs.

**No Show/No Call Policy:**

We greatly respect and value the time of our patients. We also are aware that emergencies occur. If you need to reschedule, we ask that you please give us a 24-hour notice. If you miss your appointment and fail to contact prior to the 24 hours a fee of **\$50.00** for your appointment will be required at the time of scheduling future appointments. The deposit will be applied to your bill, treatment, or retained should you fail to show.

**Treatment Understanding:**

Your treatment is tailored to your individual needs. At the time of planning your treatment, you will be provided with financial options. These options and pricing for treatment are valid for **30 days**. After **30 days** treatment plan is null and void, and subject to change. If treatment is scheduled after the **30 days**, treatment plan will be provided at current pricing and fees.

**Financial Agreement:**

It is the policy of this office, that payment is due at the time of scheduling. If payment cannot be paid in full at the time of scheduling, we offer payment plans. Our payment plans are coordinated in a way to make things as easy and affordable as possible for you. Payment plans can be discussed and arranged with our Financial Coordinator in person or over the phone.

**Dental Insurance:**

We are dedicated to working with you and your insurance to maximize your dental insurance benefits and filing your claims. We are committed to estimating insurance as closely as possible, but it is an estimate based on information provided by your insurance. Our relationship is with you, our patient, not the insurance company. Therefore, if your insurance company fails to honor our request for payment, you are responsible for the entire balance.

We are devoted to working with you and your insurance company to maximize your dental insurance benefits and filing your claims. We are committed to estimating insurance as closely as possible, but it is an estimate based on information provided by your insurance company.

By signing below, I fully understand that if insurance fails to pay any portion of my visit, I am responsible for the payment in full.

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Signature and Date

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Relationship to Patient if Signing for Patient