West Kootenay Community TEETH Clinic
A Successful Life Begins with a Healthy Smile

PATIENT AGREEMENT

Date _____

I, _____, understand that I am responsible for the cost of treatment provided by the Teeth Clinic to be fully paid on the date of treatment. Payments can be made in cash, cheque or credit (Mastercard or Visa). We also accept insurance coverage. The Teeth Clinic is authorized to process claims for treatment through a said insurance policy; however, I am responsible for any portion of the treatment costs not covered by insurance.

I further understand that if I do not come to my scheduled appointment or if I cancel less than 48 hours in advance, I must pay a NO SHOW fee of $30.00. This fee will need to be paid in order to reschedule a missed appointment.

_____

Signature