The Bell Dental Group

ALONZO M. BELL, DDS
1454 Duke Street
Alexandria, VA 22314

APPOINTMENT POLICY

We view an appointment in our schedule as a bond of trust: we will be here to serve you and you will be present and on time for treatment. Our appointment policy is firm in this regard, and we cannot accept frequent cancellations or consistent short-notice changes.

As a courtesy, we can give you a call on the business day before your scheduled appointment to remind you of your appointment. We will try to contact you personally or leave a message for you at either your work or home phone numbers. Please remember that this is done only as a courtesy to you and that we expect our patients to take full responsibility for their scheduled appointments.

If you need to change your scheduled appointment, please be advised that changes must be made 48 hours in advance. Scheduled appointment changes will only be accepted during our business hours, or a broken appointment fee of $110.00 will be assessed.

TREATMENT AUTHORIZATION

I hereby authorize Alonzo M. Bell, D.D.S. to take x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by Dr. Bell to make a thorough diagnosis of the patient's dental needs. I also authorize Alonzo M. Bell, D.D.S. to perform any and all forms of treatment, medication, and therapy that may be indicated and mutually agreed upon.

FINANCIAL & INSURANCE POLICY

I understand that I am fully responsible for all dental fees, and I further understand that my dental insurance is a contract between the insurance carrier and me and **not** between the insurance carrier and the office of Dr. Bell. I also assign all insurance benefits to the office of Dr. Bell unless treatment is paid in full. Any payments received by Dr. Bell from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred in full. My dental fees are due and payable at the time services are rendered; I further understand that a finance charge of **1.75%** per month will be applied to my unpaid balance. I have been provided and fully understand the written **Office Financial Policy,** in addition, I understand that if my account becomes past due, that I will be responsible for the total of my account plus all collection costs including attorney fees up to 25% of the balance.

Your signature below indicates your acceptance of the above office policies.

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Patient Signature, Legal Guardian, or Responsible Party Date