Office Policy

Me Smile Dental

Dear Patients,

Thank you for choosing Sunrise Dental as your family dental provider.
We look forward to providing you high quality dental care at an affordable price.

When scheduling your appointments, we are making a commitment to you.
Please remember that we have reserved a special time for you. If you find a need to reschedule your appointment, we ask for a minimum of 48 hours notice.
Failed appointments and canceled appointments without 48 hours notice are subject to an $85.00 fee.

Checks returned for insufficient funds are subject to a $35.00 fee.
This fee is enforced to cover our bank charges. Please let us know if special arrangements must be made.

Patient portion is due at time of service. Please bring your co-payment with you.

We bill your insurance as a courtesy to you. If any amounts are denied or not covered, the balance owing is your responsibility. Your estimated patient portion for services is based upon the information provided by your insurance company, and is expected on the day treatment is rendered. Please ask for an estimate, if one has not already been given to you.

I declare that I am not a recipient of state assisted insurance, including but not limited to, DSHS. If I am, I am fully aware that the office will not bill DSHS nor are they a provider for DSHS.

Patient acknowledges in consideration for dental services to be rendered any outstanding debt to our office will not be included in any bankruptcy petition.

Unfortunately, we do not have the resources to maintain adequate supervision of children.
Please refrain from bringing unattended/unscheduled children.

Thank you again for your understanding and care with helping to keep our facilities safe and clean and helping us provide you with the best possible dental care.

Patient: _____

Date: _____

Signature: _____