FINANCIAL AGREEMENT

I understand that by signing this document I am responsible for any financial obligations for Dental Treatment that **Dr. Alice B. Deutsch** at **Garden City Dental Care PLLC** has provided for myself or a family member.

I further understand that I am responsible for any charges for services rendered which are not covered by my Dental Insurance.

We accept Cash, Checks, and Credit Cards. If your treatment is extensive we offer serval payment options. If you would like to keep a Credit Card on file with our office for a payment plan, please discuss the details and process with our office manager.

APPOINTMENT CANCELLATION POLICY

At Garden City Dental Care, we value your time and do our best to accommodate your schedule. If you cannot make an appointment as scheduled, please notify the office as soon as possible.

There will be a charge of $50.00 per 60 minutes of scheduled time broken for a missed appointment, or cancellation with less than 24 hours' notice.

SIGNATURE:_____ DATE: _____

AGREEMENT OF PAYMENT FOR MINOR

I understand that as a parent or legal guardian to the patient that I will be authorized to make the payment on their behalf.

SIGNATURE: _____ DATE:_____

RELATIONSHIP TO PATIENT: _____

Garden City Dental Care, PLLC
120 Seventh Street
Suite 203A
Garden City, NY 11530