ardental

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513 -1207 Douglas Street, Victoria BC, V8W 2E7

FINANCIAL AND RESCHEDULING APPOINTMENTS INFORMATION

It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. Part of this care includes outlining the following information of our practice.

Office Hours

We are open from Monday through Thursday from 8:30am to 4:30pm. Some extended days are offered by appointment only (appointments available for 7:30am on Mondays & Wednesdays)

Rescheduling Information

We appreciate that it may become necessary to reschedule an appointment. Please understand that this appointment has been reserved specifically for you. In order to accommodate the needs of our patients and avoid a Missed Appointment fee of $50.00 for a short appointment (1 hour or less) and $100.00 for appointments longer than 1 hour, we ask for two business days' notice in order to change your appointment. The reason why we ask for 2 business days' notice is because we have a number of patients on our "priority list". They require appointments on short notice as they are suffering or in pain. Each person's situation is different and we realize that family, office emergencies, and illness can arise. We will be pleased to discuss the details of short notice appointment changes on an individual basis.

Payment Information

Please note: We require full payment at the time of treatment, including any insurance co-payments.

As a courtesy to our patients we are pleased to submit your dental claim on your behalf, as well as accept direct settlement from your insurance company. Please keep in mind that we provide this service as a courtesy for our patients and we do our best to keep track of your insurance frequencies. Ultimately, it is your responsibility to contact your insurance company if you are concerned about why a service was not covered. *Also, please note any treatment that your insurance does not pay or exceeds the limit of your individual plan will be your responsibility and billed directly to you.*

My signature below confirms that I have read, understood, and agree to these policies of Dr Anna Rankin's Dental Office.

Date_____ Patient Signature_____