BOUDREAU FAMILY DENTAL
SMILE CARE FOR LIFE

JACQUES BOUDREAU, DMD
CYNTHIA YERED, DMD

OFFICE COMMUNICATIONS PREFERENCES

In case our office needs to contact you regarding an appointment, balance, or other treatment-related needs, we will attempt to reach you first on the cell phone you provided to us, then on your home phone.

If you prefer us to use a different contact number, please provide: (______) _______ - __________

I understand that this authorization will remain in effect until terminated by me in writing

Signed: ____ Date: _________________________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Boudreau Family Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf of my dependents.

I authorize Dr. Boudreau, Dr. Yered, or any other provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed: ____ Date: _________________________

CANCELLATION POLICY

We know your time is valuable, and ours is too. Out of respect for our staff and our other patients, we ask that you give at least 24 hours' notice if you need to cancel an appointment.

- The first two times a patient misses an appointment without 24 hours notice, we will make a note in your file.
- All future unannounced missed appointments will incur a $50 fee.

I understand the policy for cancelling appointments, and the potential fee for multiple missed appointments.

Signed: ____ Date: _________________________

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