Amanda R. Donnelly, D.M.D.
742 Graham Road, Suite A
Cuyahoga Falls, OH 44221
330-929-2616

Thank you for choosing Dr. Donnelly as your dental care provider. Our goal is to provide excellent dental care with exceptional customer service. Our professional staff will help you maximize your insurance plan benefits. Please remember, your insurance is a contract between you, your employer, and the insurance company. We make every effort to obtain your full insurance benefits; however, we cannot guarantee what your insurance will pay. **If your insurance company denies coverage, or if we do not receive payment within 90 days from the date of service, the balance due will become payable by you.**

Assignment and release:

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information and x-rays requested by my insurance carrier.

Patient Signature: _____ **Date:** _____

Payment Options:

Payment for services is due in full at the time they are provided (after deduction of estimated insurance benefits, if applicable). Cash, Check, Visa, Master Card and Discover are accepted.

CareCredit --- a NO interest monthly payment plan is offered for balances of $200.00 or more.
Ask for details on payment plan options.

****A Service Charge of $25 will be applied to your account for all returned "NSF" checks****

Cancellation Policy

We recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demand of our daily lives. Therefore, we have developed a cancellation policy that is fair to both our patients and our practice. If tardiness or cancellations become habitual, we reserve the right to charge an appointment cancellation fee or terminate a patient's care at our office.

_____ We request 24 hour (business day) notice for cancellations or rescheduling of appointments.
Please initial Cancellations with less than 24 hours notice will be subject to a $50 fee.

I have been informed of and agree to the above policies for the office of Dr. Amanda Donnelly.

Patient Signature: _____ **Date:** _____

(Revised 02-2016)