

**WELCOME TO
Marketplace Dental Excellence
RAY W. TUCKETT, DDS, FAGD**

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. In order to keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines:

APPOINTMENTS:

Our office hours are as follows:

Monday	7:00 a.m. to 4:00 p.m.
Tuesday	7:00 a.m. to 3:00 p.m.
Wednesday	7:00 a.m. to 4:00 p.m.
Thursday	7:00 a.m. to 3:00 p.m.

Please note that the 7:00 a.m., the 12:00 noon, and late afternoon appointments are the most popular.

CANCELLATION POLICY:

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give our office advanced notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way we can best serve the needs of ALL patients.

Bearing these special needs in mind the office requires a minimum of 24 hours notice if an appointment must be cancelled. If less than 24 hours notice has been given to cancel an appointment, a \$50.00 fee* will be assessed. In the event that no notice is given and the patient does not show up for their scheduled appointment, then a \$75.00* fee will be assessed. Please note that this fee is not covered by dental insurance and payment is the patients' responsibility.

** Exceptions will be made for illness or personal tragedy.*

PAYMENT POLICY:

Unless prior arrangements have been made, payment is due upon completion of treatment. Please note, not all services may be covered by your insurance carrier and every insurance plan has its own unique "quirks" and exceptions. It becomes the patients' responsibility to cover procedures that are not covered by their insurance plan.

We at Marketplace Dental Excellence look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I have read the above policies and understand my responsibility as a patient.

Patient Signature

Date