



Lake Elmo Professional Center
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Welcome to Our Practice

We would like to take this opportunity to thank you for choosing our office to provide your dental care. We hope you always feel welcomed and comfortable when you come to see us. We are committed to giving you the best service possible and want you to be happy here in your dental home. Below are some items that will help us to achieve our common goal of high quality dental care in a gentle and enthusiastic environment.

We will do our best to give you a "guestimate" of your investment in your dental health for each upcoming visit, based on your treatment needs. You will be responsible for your portion at each visit and as a courtesy to you; we will accept assignment of benefits on your behalf from your dental insurance company. Any payments going directly to you by your insurance company for services you received in our dental office should be forwarded to us immediately so that we can credit your account accordingly.

We realize that you have many demands on your time. We are committed to respecting your time and will attempt to make your visits as convenient as possible. In return we ask that our patients respect our time. In the event you need to change your appointment we request a 48- hour advanced notice. We thank you in advance for your prompt attention to this request.

We are happy to receive payments in the form of cash, check, or credit card (MasterCard, Visa, AMEX and Discover). We also offer no interest or low interest monthly payments through Care Credit.

(See us for details or visit their website at www.Carecredit.com) In the event that you inadvertently write a check to our office without sufficient funds in your account a returned check fee of \$35.00 will be added to your account.

Thank you again for trusting us with all your family's dental needs. We look forward to serving you and your family.

I understand and accept the financial and appointment policies listed above and have had any and all questions answered to my satisfaction. I hereby authorize my insurance benefits to be paid directly to Dr. Bagby. This request will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

X _____

Patient (or legal guardian)

X _____

Date

Staff Initials