DR. DALESANDRO & ASSOCIATES
FAMILY OWNED SINCE 1978

Dear Patients,

Please be aware that we charge $45 for failure to give us at least a **2 working days'** notice of change to any existing appointments. In order to avoid this fee, we do appreciate that you will keep this in mind when changing your dental appointments in the future.

Date: _____ Patient Signed: _____

By signing below I acknowledge that my insurance will be billed as a courtesy, it is my responsibility to know my insurance benefits and limitations.
I understand that payment is due at time of services rendered.

Date: _____ Patient Signed: _____

Thank you for your understanding in this matter.

Sincerely,
Dr. Dalesandro & Associates