Wilfred J. St. Cyr D.D.S
2114 Edmondson Ave
Catonsville, MD 21228
(410) 747-6910

Welcome to Our Practice

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior service, the Office Policies and Procedures in the following areas of concern. Please initial each item below.

_____ Policy on Cancellations & Rescheduling (Need 48 Hours Minimum)

_____ Failure to give proper above notice will result in a $50.00 recovery fee. This is not a *penalty*! This is for supplies that cannot be re-shelved.

_____ NSF Check Recovery Fee ($35.00). (Thereafter, Cash Only).

_____ Insurance Billing (Insurance Companies are billed the same date of service).

_____ Patient Statements (We send out 1 Statement per month)

_____ Notification of Insurance, Address and/ or Job Change (Your Responsibility).

_____ It is a State law for parents /guardian of a child under the age of 16 to remain in the office while the child is being treated.

My initial above and my signature below signifies I have read the above and understand the counseling I have received.

Patient's Printed Name _____

Patient's Signature _____ **Date**_____