



Suite 304 - 15230 Highway 10 • Surrey BC • V3S 5K7

Welcome to our clinic! We strive to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment.

Appointments

Our office is open extended hours for the convenience of our patients, and in consideration of work and school schedules.

Cancellation Policy

There are many times when our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the clinic advanced notice of their need to cancel a scheduled appointment, this time can in turn be allocated to patients needing urgent treatment. We want to help everyone!

Bearing this in mind, **the clinic requires a minimum of 48 hours notice if an appointment must be cancelled.** If less than 48 hours notice is given to cancel an appointment, a \$50.00 fee* will be assessed. Please note that insurance companies do not cover short notice cancellation fees, therefore payment is the patient's 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. As a courtesy to our patients, we will accept insurance plans and will work with you to understand your benefits. Many plans will not provide us with breakdowns due to client privacy and will only want to speak with the policy holder (you). Please note that not all services may be covered by your insurance carrier and you are responsible for payment of your dental treatment. Please notify us immediately if there are any changes to your dental insurance coverage.

I, _____, have read the above policies of Panorama Place Dental Centre and understand the short notice and cancellation policies.

Date

Signature

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company:	Insurance Company:
Group #:	Group #:
Certificate #:	Certificate #:
Policy Holder:	Policy Holder:
Birthdate:	Birthdate:
Employer:	Employer:
Coverage %:	Coverage %:
A: B: C:	A: B: C:
Yearly limit:	Yearly limit:

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Date

Signature of patient, parent or guardian

I hereby assign my benefits, payable from claims submitted electronically, to Panorama Place Dental Centre (specific dentist will be provided in each claim) and authorize payment to them directly. This authorization shall continue in effect until the undersigned revokes the same.

Date

Signature of plan member