MDS MOBILE DENTISTRY SOLUTIONS
COMPASSIONATE DENTAL CARE

7575 San Felipe Suite 101 Houston, TX 77063
Phone (832) 716-0909 Fax (855) 827-7442
contact@mobiledentistrysolutions.com

FINANCIAL RESPONSIBILITY FORM

Thank you for choosing MDS for your dental needs! We take pride in providing patients with convenient quality dental care. Specializing in on-site care, we offer a range of dental services with unprecedented convenience. Each patient or responsible party may choose from one of our payment options below. We have structured our prices to rival those of traditional dental offices in the Houston area. Payment for additional preventative or restorative visits will be handled separately as those needs arise. Please contact our office if you have additional questions. We look forward to serving you!

Please check the box next to the option that best fits your preference for paying for routine dental services:

☐ The patient or responsible party will pay by check, debit or credit card **at the time of service**.

☐ The patient or responsible party will arrange payment by check, credit or debit card **prior to the time of service**.

☐ The patient or responsible party will provide a form of payment guarantee to be kept on file and be invoiced for services provided. Guarantor agrees to forward **payment in full within 10 Days of receipt of invoice**.

Missed Appointment/Cancellation Policy

Onsite delivery of high-quality dental care to those in need is a uniquely special segment of dentistry. When appointments are booked, we are reserving the doctor, team and transport of dental equipment just for that patient. Rather than charging more for onsite care we provide a discount of the average prices in Houston. Therefore, cancellations must be made at least 24 hours prior to the scheduled appointment to prevent a late cancellation or no show fee of $50.00. Cancellations can only be accepted during regular business hours. Nights, weekends and holidays are not included in the 24 hour cancellation period.

Signature

	/ /
Signature of Patient or Responsible Party (if Applicable)	**Date**

My signature above indicates that I have provided the most accurate patient information possible and assume responsibility for inaccuracies and omissions.

Responsible Party Info:

			/ /	
First	**M I**	**Last Name**	**DOB**	**M or F**

Relationship to the Patient: ☐ *Son* ☐ *Daughter* ☐ *Husband* ☐ *Wife* ☐ *Relative* ☐ *Other*