Bruce Martinson Family & Cosmetic Dentistry

Patient Terms & Conditions

317 E. Wayzata Blvd., Wayzata, MN 55391
Phone: 952-473-4639 | Email: office@martinsondental.com Website: Martinsondental.com

Thank you for choosing our practice. These policies explain what you can expect from our office and help us provide considerate, efficient care.

1. Appointments and cancellations

Your appointment time is reserved especially for you. Please provide at least 48 business hours' notice if you need to cancel or reschedule.

Missed appointments or cancellations with less than the required notice may result in a fee of $50.00, subject to applicable law and insurance requirements. We understand that emergencies happen; please contact us as soon as possible so we can discuss your circumstances.

If you arrive late, we may need to shorten or reschedule your appointment to allow adequate time for safe care.

2. Payment and financial responsibility

Payment is expected at the time of service/unless another arrangement has been approved in advance. We accept Visa, Mastercard, American Express, Discover, Checks, Cash and Care Credit

We will explain proposed treatment and estimated fees before treatment begins whenever practical. Please ask about costs or payment arrangements before proceeding.

You are responsible for amounts properly owed under your treatment agreement, insurance coverage, and applicable law.

3. Dental insurance

Please provide current insurance information and notify us promptly of any changes.

Insurance benefit estimates are not guarantees of payment. Your insurance company determines coverage and benefits under your plan. We will assist with claims as described in our office's billing procedures.

Any remaining patient balance will be billed after applicable insurance payments and adjustments. Payment is due within 7 days of the statement date.

4. Treatment decisions and consent

We encourage you to ask questions about your dental health, recommended treatment, alternatives, fees, and expected results.

Signing this policy acknowledges office policies only. It does not replace any treatment-specific informed consent that may be required.

5. Health and contact information

Please provide accurate health history, medication and allergy information, and contact details. Notify us of changes before treatment, including changes in medical conditions or medications.

6. Privacy and communications

Our Notice of Privacy Practices explains how health information may be used and disclosed and describes your privacy rights.

Please tell us your preferred contact method. Any permission for text messages, emails, or marketing communications will be addressed separately where appropriate.

7. Respectful environment

We ask patients, accompanying guests, and team members to treat one another respectfully. Threatening, abusive, or unsafe behavior will be addressed promptly.

Patient acknowledgment

I acknowledge that I have received and reviewed these office policies and have had an opportunity to ask questions.

Patient name:

Parent/legal guardian, if applicable:

Signature:

Date: