

**Foxboro Dental Associates Inc**  
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Dear Patient,

On behalf of the whole Foxboro Dental Associates team, we welcome you to the practice.

Serving Foxboro and surrounding communities since 1962, our mission statements below reflect a continued commitment to our patients.

In summary, we strive to foster patient relationships based on mutual trust, excellent customer service and the best patient care available.

- Office hours are

Monday	7:30 am – 7:30 pm
Tuesday	7:30 am – 4:30 pm
Wednesday	7:30 am – 4:30 pm
Thursday	7:30 am – 6:30 pm
Friday	8:00 am – 3:00 pm
Closed for Lunch	1:00 pm – 2:00 pm (except Fri)
  
- Patients of record with a dental emergency after hours can call and speak with one of our on call dentists.
  
- As long as we receive at least 48 hours notice of your need to change your appointment, there will be no charge. However, should we not hear from you at least 48 hours prior to your scheduled appointment of your need to reschedule, there will be a \$50 charge for each half hour missed. We are sure that this will not be an issue.
  
- As a *courtesy* to our patients, we will submit for services rendered, to dental insurance companies on *your* behalf. Your dental insurance status is typically updated on the day of your visit. Co-payments are calculated and collected at time of service unless alternative arrangements have been made. Our patients are responsible informing the office of changes to their dental insurance coverage. Ultimately our patients are responsible for services not covered by their dental insurance.

- Payment is expected at time of services rendered. Acceptable methods of payment include cash, check or credit card. Third party financing including interest free options are available.
- Returned of bounced checks are subject to a \$25 fee.
- During the winter months in the event of snow, please be assured that we will make every attempt to call you, should the office need to close.
- For more information visit us at [www.foxborodental.com](http://www.foxborodental.com).

Patient Signature\_\_\_\_\_

Date\_\_\_\_\_

Practice Administrator\_\_\_\_\_

Date\_\_\_\_\_