Welcome !

All of us at **John S. K. Hsu D.D.S. & Virginia J. Chin D.D.S., P.C.** would like to thank you for choosing us for your dental care providers. We are dedicated to the maintenance of good oral health and providing professional services required to maintain your healthy state.

You may be assured our staff members are interested and concerned for your well being. We encourage open communication and are available to answer any questions regarding your condition and/or financial arrangements.

We want you to know how much we appreciate your confidence in choosing our office for your dental needs and look forward to seeing you.

Your scheduled appointment time is time reserved especially for you. If you are unable to keep your appointment, please give our office at least 24 hour notice.

There will be a **Fifty ($ 50.00) dollars fee** for appointments missed without **24 hour advanced notice**.

Sincerely,

Dr. Hsu, Dr. Chin and Staff

Patient's Signature:_____ Date: _____

INSURANCE AUTHORIZATION

John S. K. Hsu D.D.S. and
Virginia J. Chin D.D.S. , P.C.
10801 Main St. Suite 500 & 600
Fairfax, VA 22030

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance carriers
- I understand that I am responsible for my bill
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original

Name:_____
(Please Print)

Signature: _____ Date:_____