Patient Information

Patient Name: _____

Relationship to patient: Self [__] Spouse [__] Guardian [__] Other [__]

FINANCIAL POLICY

Thank you for choosing us as your dental provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement from our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Your dental provider accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The dental benefit contract is an agreement between you and the dental benefit company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, your dental team may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that your dental plan is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

PAYMENT:

Payment for services, including deductibles and copayments, are due at the time of the service unless other arrangements have been made prior to treatment. This includes but is not limited to dental fees, surgical procedures, tests, office procedures, medications, and any other services not directly provided by the dentist.

Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment. For more information on what third-party financing options your dental provider accepts, please contact your dental team.

Checks that are returned to our office from your financial institution may be subject to a returned check fee. This fee covers the processing fees that are charged to our office. Please indicate your understanding and acceptance of these financial policies by signing below.

*__Full payment__ *is due at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service, unless other arrangements are made.*
*__Unpaid balances over 90 days__ *(about 3 months) old may be subject to a monthly interest charge. If payment is delinquent, the patient will be responsible for payment of collection, attorneys' fees, and court costs associated with the recovery of the monies due in the account.*

By signing below, you indicate your understanding and acceptance of the aforementioned financial policies.

Printed Name: _____ ***Signature:*** _____

APPOINTMENT POLICY

If you find that you must change your appointment, a minimum of 24 hours or 1 business day notice is required.

Your appointment represents a reservation for time with your dental team to provide your service and adequate notice of a needed schedule change offers us the ability to redirect our resources to other patients and their necessary treatment.

If proper notice is not received, a fee may be charged for each changed appointment.

By signing below, you indicate your understanding and acceptance of the aforementioned Appointment policy.

Printed Name: _____ ***Signature:*** _____

CONSENT FOR THE USE OF PHOTO/X-RAYS

Clinical Imagery plays a key role in the education of medical and dental staff at all levels, and thus benefit future patients.

**I grant my dental team permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders.*

**I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance.*

**I do consent to the use of my photographs or images for marketing materials including website and patient education.*

I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used.* **No full face or comparable photos will be used without your express written authorization.

**I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications.*

**I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.*

***By signing below, you indicate your understanding and acceptance of the aforementioned statements, and you authorize and consent to the use of photographs/x-rays of me taken by my dental team.**

Printed Name: _____ ***Signature:*** _____