Office Policies

No show fees

I understand that I am required to give 24-hour notice if I am unable to keep a scheduled appointment. If proper notice is not given, there will be a no-show fee. Those fees are charged at $45 per hour scheduled. I also acknowledge that 2 missed appointments could lead to dismissal from the practice.

Notice of HIPAA / privacy practices

I acknowledge that a copy of the privacy practices is available on the last page of this packet, and that I may request a copy at any time. Information can also be found at www.hhs.gov/programs/hipaa/index.html

Assignment of insurance

I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office, benefits according to me under my policy. I understand that the fee estimates I'm given are based on insurance contracts and the coverage information give by the insurance company. They are not a guarantee of payment. I understand that dental services furnished to me are charged directly to me, and that I am personally responsible for payment. If I carry insurance, I understand that this office will prepare and file insurance claims on my behalf, but I am responsible for all fees unpaid. I understand that fees are due on the date of service unless other arrangements have been made prior to treatment.

Informed consent

I acknowledge my dental treatment may include examinations, X-rays, cleaning, gum disease treatment, fillings, root canals and prosthodontics, usually with local anesthesia. I understand that if the decay in a tooth is very deep and a filling is done, it may require a root canal in the future.

Signature of patient/guardian _____date_____