OFFICE AND FINANCIAL POLICIES

1. **General Consent To Treatment** I hereby authorize my doctor and designated staff to perform any and all forms of procedures deemed appropriate by the doctor, which include but not limited to examination, radiographic survey, dental cleaning, restoration and filling of teeth, gum treatment, extraction, etc., to enable a thorough diagnosis and treatment for (name of patient) ________________________________.

2. **Adult / Minor Patients** Adult patients are responsible for full payment at time of service. The parent/guardian who brings the minor patient in for treatment is responsible for payment. Our office will not provide service for unaccompanied minors unless consent to treat and advance financial arrangements have been made.

3. **Dental Insurance** I understand that I am solely responsible for my entire account balance regardless of my insurance. Any insurance benefits or coverage information provided, as a courtesy to me by this office, is not a guarantee of eligibility or payment. I shall be responsible for any remaining balance, fees, deductibles, estimated portions and co-payments for my account.

4. **Assignment of Dental Benefits** I assign dental benefit payment from my insurance company to be paid directly to the doctor. I authorize the release of this form, and any medical and dental information necessary for the process of my insurance submissions.

5. **Late Charge** A late fee of $25.00 will be added to the remaining balance if payment is not received by the due date.
   Returned Check A service fee of $25.00 will be applied to each returned check.
   Default Ten days after the due date without payment, the account will be consider in default. In such a case, the entire balance shall become past due, including all collection fees and charges.

6. **Appointment Policy** It is your responsibility to remember your appointment. Please notify us 48 hours in advance if you are unable to keep your appointment. Failure to do so will result in a broken appointment charge of $50.00 on your account.

I have read, understand, and agree to comply with the foregoing Office and Financial Policies. I will ask for further explanation if I have any questions regarding these policies. I understand that I am entitled to have a copy of this form.

Signature of Patient/Guardian ______________________________________ Date ________________

Receipt of Notice of Privacy Practices & Dental Material Fact Sheet

My signature below indicates that I have received a copy of:
1) This office's **Notice of Privacy Practice**
2) The **Dental Materials Fact Sheet** developed by the Dental Board of California.
We are required by law that each patient be given a copy. It discussed and compared many types of dental Materials to restore cavities and to replace missing teeth.

Signature of Patient/Guardian ___________________________________ Date ________________

For Office Use Only

We were unable to obtain written acknowledgement of receipt of foregoing documents because:
_____ Individual refused to sign
_____ Communication barriers prohibited us from obtaining such acknowledgement
_____ An emergency situation occurred
_____ Others Reasons ____

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