Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Consent for Services

Performance: I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. Due to the progressive nature of dental disease, a new examination and treatment plan may be needed after a period of twelve months from the date of the original patient examination.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

There is very limited space in our operatory we want all of our patients to be comfortable and have the privacy that they deserve while receiving treatment, therefore, **only patients** are allowed in the operatory! It is absolutely imperative that all minors be accompanied by a parent or legal guardian to each appointment.

We allow a 15 minute grace time for all appointments. If you are more than 15 minutes late to your appointment it is at the office's discretion as to whether or not you will need to reschedule your appointment.

Fees: I understand that the treatment plan and associated fees are only an estimate and are subject to change depending upon individual circumstances.

I agree to be responsible for payment of all services rendered on myself or my dependents behalf. I understand that payment is due in full at the time of service. Outstanding balances are subject to a 5% monthly APR and a $10 monthly late fee. I understand that I will have to pay for any and all court and attorney fees that result from a court case arising from my failure to pay for dental services in a timely manner as well as all collection fees, as determined by this dental office. I further understand that a $ 50.00 broken appointment fee will apply if I fail to give 24-hours advance notice to reschedule and appointment for any dependents or myself.

In the unlikely event that your check is returned for insufficient or held funds, we will debit your checking account electronically for the face amount of the check PLUS the state-authorized fee of $50. This policy allows us to resolve the problem without reporting you to a credit bureau and harming your credit rating. The transaction will appear on you bank statement, and no one will have to contact you about payment.

I have read the above conditions of treatment and payment and agree to their content.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: you have the right to read our Notice of Privacy before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you of you revoke this consent.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party