Family Dentistry Policies

- As a courtesy to other patients, there is a 24-hour notice of cancellation required. The first time a patient fails to give adequate notice, a reminder will be given. However, after the second offense a $50.00 fee per half-hour may be charged.
- This $50.00 per half-hour fee also applies to " no show " appointments. Multiple " no show " and " broken " appointments may result in patient dismissal.
- Please be aware that there is a returned check fee of $40.00 and multiple offenses may result in a cash payment only.
- Unpaid account balances will incur a service charge of 1.5% per month after 60 days regardless of any insurance involvement.
- Balances of 90 days or more, unless on a payment plan or other special arrangement, will be dealt with through legal action or collection agency if it becomes necessary. Should collection action become necessary, all fees associated with collection costs are the financial responsibility of the account Responsible Party, thus increasing the total balance due.
- Recurrent failure to comply with special financial agreements can result in legal action or postponement of future appointments until a resolution is made and all debt is satisfied. Signed financial agreements are legally binding.
- For appointments requiring an extended length of time, the patient may be asked to secure the reserved time with their provider of care with a prepayment. We reserve the right to hold prepaid visits as non-refundable.
- We will make every reasonable effort to help with insurance involvement, but please understand that insurance company policies are arrangements between the insurance company and the patient. The dentist is a third party and cannot be responsible for all debt occurring with the dentist regardless of the amount, if any, the insurance company decides to pay.

X _____

Signature: Patient or Parent or Guardian Date

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of _____ and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

   A. Preventive hygiene treatment, (prophylaxis) and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   D. Replacement of missing teeth with dental prostheses, (bridges, partial dentures, full dentures).
   E. Removal (extraction) of one or more teeth.
   F. Treatment of diseased or injured oral tissues (hard and/or soft).
   G. Use of sedative drugs to control apprehension and/or disruptive behavior.
   H. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
   I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, an that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgement of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I agree to the use of local anesthesia, depending on the judgement of the doctor/s. I understand and have been informed of the above risks and complications.

7. I also authorize the doctors to use photographs, radiographs, other diagnostic material and treatment records for the purposes of teaching, research and scientific publications.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____AM/PM File No: _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

X _____

Signature: Patient or Parent or Guardian Witness