Authorization for Release of Information to Family and/or Friends

Name of Patient: ____________________________ Date of Birth: ___________________

Southlake Family and Cosmetic Dentistry is authorized to release protected health information about the above named patient to the entities name below.

Entity to Receive Information. (Please initial each item subject to this authorization.)

__________ Leave information on answering machine or voice mail

__________ Give information to spouse.

__________ Give information to the following persons: _________________________________

Description of Information to be Released.

__________ Financial information.

__________ Family billing information.

__________ Information results from test or x-rays.

__________ Medical information as follows: ____

__________ Other information as described: ____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Southlake Family and Cosmetic Dentistry

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in full force and effect until revoked by the patient or representative signing the authorization.

____ Date: ___________________
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (Attach necessary documentation)

____

Medical History

Name: ______________________________ ☐ **Male** ☐ **Female**
Address: ______________________________ **Date of Birth:** ______________________
City, State, Zip: ______________________ **SSN:** ______________________________
Home Phone: ________________________ **Marital Status:** ______________________
Work Phone: ________________________ **E-Mail:** **(fill in to receive E-mail correspondence)**
____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No ______________________
Have you ever been hospitalized or had a major operation? ○ Yes ○ No ______________________
Have you ever had a serious head or neck injury? ○ Yes ○ No ______________________
Are you taking any mediations, pills, or drugs? ○ Yes ○ No ______________________
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No Do you use any tobacco products? ○ Yes ○ No
Are you on a special diet? ○Yes ○ No Do you use any controlled substances? ○ Yes ○ No

Women: Are you ☐ **Pregnant/Trying to get pregnant?** ☐**Nursing?** ☐**Taking Oral Contraceptives?**

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetic ☐Other ______________________

Do you have, or have you had, any of the following?

☐ AIDS/HIV	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatment	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○Yes ○No ○N/A

Comments: ____
____
____

***Conditions may require medication N/A-Not answered by patient**
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

____
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

DENTAL HISTORY

What is the reason for your visit today? ____________________

Previous Dentist's Name ____________________ Address ____________________

Date of Last Visit ______________ Last Hygiene Visit ______________ Last X-Rays ______________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other aids do you use? (Electric toothbrush, toothpick, etc.) ____________________

Do you have any dental problems now? Yes No

If yes, please describe ____________________

Are any of your teeth sensitive to:

Hot or cold? . . . . . Yes No
Sweets? . . . . . Yes No
Biting or pressure? . . . . . Yes No
Have you ever noticed any mouth odors or bad tastes? . . . . . Yes No
Do you frequently get cold sores, blisters, or any lesions? . . . . . Yes No

Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? . . . . . Yes No
Have you noticed any loose teeth or change in your bite? . . . . . Yes No
Does food tend to become caught between your teeth? . . . . . Yes No

Do you: Yes No
Clench or grind your teeth while awake or asleep? . . Yes No
Have tired jaws, especially in the morning? . . . . . Yes No
Bite your lips or cheeks regularly? . . . . . Yes No
Hold foreign objects with your teeth? (pen, pipe, etc) Yes No
Mouth breathe while asleep or awake? . . . . . Yes No
Snore? . . . . . Yes No

Have you ever experienced:
Clicking or popping of the jaw? . . . . . Yes No
Pain? (Joint, ear, side of face) . . . . . Yes No
Difficulty opening or closing the mouth? . . . . . Yes No
Frequent headaches, neck aches or shoulder aches? Yes No
Any pain or soreness in the muscles of your face or around the ears? . . . . . Yes No

Have you ever had:
Orthodontic treatment? . . . . . Yes No
Oral surgery? . . . . . Yes No
Teeth removed? . . . . . Yes No
If so, have they been replaced? . . . . . Yes No
Fixed bridge? . . . . . Yes No
Removable Partial? . . . . . Yes No
Complete Denture? . . . . . Yes No
Implants? . . . . . Yes No
Are you happy with the replacement? . . . . . Yes No
Periodontal treatment? . . . . . Yes No
Gum surgery? . . . . . Yes No
If so, when? ____________________
By whom? ____________________
Your teeth ground or the bite adjusted? . . . . . Yes No
A serious injury to the mouth or head? . . . . . Yes No
If so, please describe and include the clause:

____

____

Are you dissatisfied with the appearance of your teeth? . . . . . Yes No
Are your teeth discolored? . . . . . Yes No
Are your teeth crowded? . . . . . Yes No
Would you like to change the appearance of your teeth? . . . . . Yes No

Do you feel anxiety about having dental treatment? Yes No
Have you ever had an upsetting dental experience? Yes No
If yes, please describe: ____________________

____

How did you overcome your anxiety? ____________________

____

If there is anything else about having dental treatment that you would like us to know, please describe. ____________________

____

____

Name ____________________

FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED.
WE ACCEPT CASH, CHECK, DEBIT AND MOST MAJOR CREDIT CARDS.

INSURANCE:
Professional services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and your insurance company and payment for services is your responsibility. We will accept assignment of claim for both primary and secondary insurance. All deductibles and co-payment amounts not covered by your insurance are to be paid in full at the time of treatment. Financial arrangements must be made with the Practice Manager **prior** to starting treatment.
Our office will not enter into a dispute with your insurance company over your claim. It is your responsibility to ensure that the claim is paid. Our central insurance department will file your claim one time. **You will receive a statement every month your account shows a balance due, regardless of insurance expectations.** If at the end of sixty (60) days, your insurance has not paid, you will be responsible for the entire balance. Upon request, we will supply you with a copy of your claim so you may resubmit it if necessary. You are responsible to provide your insurance company with any additional information they may need from you. It is your responsibility to inform us of any changes in your address, phone numbers, employment and dental benefits. In order for us to honor your insurance, you must provide proof of insurance coverage (i.e. insurance card, completed claim form, or benefits book, etc.) and we must be able to verify your coverage and current benefits. If verification can not be made you will be responsible for full charges to be paid at the time of service. You will be given the proper paperwork to file with your insurance company.

USUAL AND CUSTOMARY FEES:
Our fees are what is usual and customary in our area not what your insurance company feels are usual and customary. You are responsible for any fees that are above your insurance company's usual and customary fees unless we have a contract fee with your insurance company or are a participation preferred provider (PPO) for you insurance company.

FEE SCHEDULES:
Some insurance plans pay from a fee schedule. We may not have your insurance company's fee schedule. In order for us to accept assignment for your insurance, you will need to provide us with a copy of your fee schedule. You will find this in your benefits book or you can obtain it from you human resources department.

BROKEN APPOINTMENT POLICY:
Please consider your scheduled appointments carefully. We require a 24 hour cancellation notice. If we do not receive a 24 hour cancellation notice you may be charged with a broken appointment fee that **will not** be paid by your insurance company. If you repeatedly miss scheduled appointments you will be asked to pursue treatment at our discretion.

OFFICE FEES:
If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a $25.00 fee for processing. Insufficient funds checks will not be reprocessed. You must pay by cash, credit card or money order. We will charge 1.5% monthly (18% annual) interest on all past due balances.

I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENT OULINED ABOVE.

Signed: ___________________________ Date: ________________________

Patient Financial Agreement

1. You must provide us with a copy of your dental card. If you have any changes in your insurance, you are responsible for giving us the correct insurance information.
2. We must be able to verify that you have coverage with this insurance. If we cannot verify your insurance you will have to pay for your visit in full and we will provide you with the proper paperwork to file your insurance.
3. We only verify if you have coverage and the basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you.
4. Services are rendered to you not to your insurance company. We will not be involved with any disputes you have with your insurance company.
5. If after 30 days your insurance company has not paid, it is your responsibility to call your insurance company to see why they have not paid your claim.
6. You are responsible to pay all deductibles and co-payments at the time of service. If you cannot pay in full you may set up financial arrangements prior to your service.
7. If financial arrangements are made it is your responsibility to make your monthly payment. If you fail to make your payments you may be sent to a collection agency without notice.
8. Insurance companies do not guarantee us payments so any fees stated to you are estimates only.
9. You are responsible for any monies that your insurance company does not cover, i.e. alternate benefits, denied claims due to missing tooth clause, frequency of services, age limitations, deductibles, plan limitations, etc.
10. You may have your services pre-authorized by your insurance company. This will tell us exactly what the insurance company is going to pay for your services.

I have read, understand and agree to the above responsibilities.

Patient's Name: ________________________

Signature: ____________________________

INFORMED CONSENT

PATIENT NAME:___________________________________

I hereby authorize my dentist, and whomever he may designate as his assistants and/or hygienists, to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include, but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing or new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and reinfection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

The most common of these complications in oral surgery include post-operative bleeding, swelling, or bruising, discomfort, stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and sort tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug of anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis, (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications is available to me upon request from the Doctor

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

DATE	PATIENT/PARENT/GUARDIAN SIGNATURE	DOCTOR/STAFF
__/__/__	____	____________________
__/__/__	____	____________________

Southlake Family and Cosmetic Dentistry
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer:
704-987-5050
9625 Northcross Center Court #301
Huntersville, NC 28677

Effective Date: April 14, 2003 **Revised: September 19, 2013**

We are committed to protect the privacy of your personal health information (PHI).
This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.
We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.
We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **smiles@dentistryatsouthlake.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.
EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information:

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

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Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.
Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.
There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Privacy Officer
Phone: 704-987-0505
Address: 9625 Northcross Center Court #301
Huntersville, NC 28677

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.
If you file a complaint we will not retaliate against you for filing a complaint.
This notice was published and becomes effective on April 13, 2003

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Acknowledgement of Receipt
of Notice of Privacy Practices

Patient Name: ____

Patient Address: ____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________	________________________________
Signature	Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because of the following:

- □ An emergency existed and a signature was not possible at this time.
- □ The individual refused to sign.
- □ A copy was mailed with a request for a signature by return mail.
- □ Unable to communicate with the patient for the following reason:

  ____

- □ Other: ____

  ____

Prepared By: ________________________________
Signature: ________________________________
Date: ________________________________

RESPONSIBLE PARTY Circle one: MR MRS MS DR	SECONDARY DENTAL INSURANCE
NAME:	**SUBSCRIBER NAME:**
ADDRESS:	ADDRESS:
CITY, STATE:	CITY, STATE:
ZIP CODE:	ZIP CODE:
HOME PHONE:	HOME PHONE:
WORK PHONE:	WORK PHONE:
PHONE OF NEAREST RELATIVE:	
BIRTH DATE: / / SEX: M F	BIRTH DATE: / / SEX: M F
SOCIAL SECURITY NO.:	SOCIAL SECURITY NO.:
EMPLOYER:	**EMPLOYER:**
REFERRED HERE BY:	
DENTAL INSURANCE INFORMATION	**SECONDARY DENTAL INSURANCE INFORMATION**
INSURANCE NAME:	INSURANCE NAME:
INSURANCE ADDRESS:	INSURANCE ADDRESS:
GROUP # OR LOCAL #:	GROUP # OR LOCAL #:
SUBSCRIBER #:	SUBSCRIBER #:
TITLE 19#	TITLE 19#
MEDICAL INSURANCE INFORMATION	**SECONDARY MEDICAL INSURANCE INFORMATION**
INSURANCE NAME:	INSURANCE NAME:
INSURANCE ADDRESS:	INSURANCE ADDRESS:
GROUP # OR LOCAL #:	GROUP # OR LOCAL #:
SUBSCRIBER #:	SUBSCRIBER #:

Your insurance policy is a contract between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates Payment is due at the time of service. We accept cash, checks, debit cards and Visa and MasterCard.

Any missed appointments without 24 hours notice, except in an emergency, will result in a charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY'S SIGNATURE: ______________________________ DATE: ________________ STATE: __________

PATIENT ACCOUNT REGISTRATION