Consent for Services:

I, _____ hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs and share those diagnostic tools with appropriate services to complete treatment and financial transactions. Eg: information may be shared with, but not limited to, dental labs, referring doctors and insurance.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

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

INITIAL: _____

Acknowledgement of Receipt of Privacy Practices and HIPAA Statement:

I understand the Notice of Privacy Practices and an additional copy of the HIPAA statement for Precision Dental Center is available at your new patient appointment.

INITIAL: _____

Insurance Authorization:

I authorize release of information to all of my insurance carriers. I understand that I am responsible for any part of my bill not covered by insurance. I understand that I will be billed for treatment not paid by my insurance 30 days after claim submission. I authorize payment directly to my doctor. Although Precision Dental Center is not obligated, I authorize my doctor and his staff to act as my agents in helping me obtain payment from my insurance. Pretreatment estimates available only upon request-May take 6-8 weeks for insurance response.

INITIAL: _____

Financial Policy:

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within 30 days of claim submission. I understand payment is due at time of service. In the event payments are not received by agreed upon dates, I understand that the greater of $50.00 or 1.5% late charge may be added to my account. If this account must be turned over to collections, then I would be responsible for all collection fees charged by the agency in addition to the outstanding balance on your account.

*We reserve on our schedule the necessary time for you to receive your recommended treatment. The doctor, staff, chair, and equipment have been reserved especially for you. We ask that you please give us at least 24 hours notice of any cancellation of an appointment or there will be a $25.00 cancellation fee. Thank you.

INITIAL: _____

Model Release:

From Time to time we may choose to take pictures of your teeth. We would love to be able to use those images for professional review, editorials, publications, and promotion if necessary. These images are of teeth for the most part, but may include identifiable images from time to time. If we decide to use a full face picture, you will be notified for additional consent, but otherwise we ask for your permission for unrestricted use. If this is a concern, please do not initial.

INITIAL: _____