Patient Responsibility

Please Initial on All _________s.

Authorization for Treatment

_______I authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of me or my dependent's dental needs.

_______Upon such diagnosis, I authorize doctor to perform all recommended treatment for me or my dependent which has been mutually agreed upon by me and to employ such assistance as required to provide proper care.

_______I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Consent for Treatment of a Minor

I ____ declare that I am the parent or guardian of patient, who is a minor, and am authorized to give the consents for treatment listed above.

____ ____________________

Signature Date

Notice of Information Practices *(You may refuse to initial this acknowledgement)*

_______I have read and fully understand Desert Dentistry's Notice of Information Practices.

Notice of Dental Warranty

_______I have been given a copy and understand the 6 month minimum recall required by Limited Dental Warranty.

Missed Appointments

_______ I understand that I must give 48 hour notice for any appointment that I cannot keep. Desert Dentistry does not charge patients for missed appointments; however, they reserve the right to dismiss patients who fail to give prior notice.

Financial Policy

_______ I understand that ALL responsibility for dental services provided in this office for myself or my dependents is mine. Payment is due and payable at the time services are rendered. If insurance is to be used, copay is due and payable at the time services are rendered.

Insurance

_______ I understand that any dental benefit program that I participate in is a contract between myself, my employer and the insurance company. Desert Dentistry is not a party to that contract and can only file claims as a courtesy to our patients. I understand that all services and fees may not be fully covered by an insurance carrier and that I am ultimately responsible for the payment of ALL dental services provided in this office for myself or my dependents.

_______ I understand that Desert Dentistry will estimate my insurance coverage but due to the many variable such as deductibles, annual maximums, usual and customary fees schedules, non-covered procedures and other restrictions, this office CANNOT guarantee coverage.

_______I understand that Desert Dentistry will file the forms necessary to assure I receive the benefit of my dental insurance. They will allow 90 days for the insurance company to pay. **Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days.**

_______ I understand that any account balance generated is due within 30 days of the billing date. I realize that failure to keep my account current may result in Desert Dentistry being unable to provide additional services. In the case of default on payment on this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

_______ I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my name and signature and any other required information on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

Payment Options

We want our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment.

- **Cash or Debit** (with no insurance) (5% savings!)
- **Credit Card**
- **Patient Financing** (90 day INTEREST FREE loans and longer interest bearing loans are available)
- **Procedure Payments** (For procedures that require multiple appointments, you may make 2 equal payments. The first payment is due the day the procedure is begun and the second payment is due on the day it's delivered. The negative here is NO DISCOUNT.)

I comprehend the information on this form and understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient ____ Date ______________ Witness _________________

Parent or Responsible Part ____ Relationship to Patient ___________