



Patient Responsibility

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.

_____ I consent to the use of appropriate medication as deemed necessary. I fully understand that using anesthetic agents and nitrous 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

Photo and Video Consent

_____ I give Desert Dentistry consent to use my photo and video for the purpose of patient recognition, treatment presentation or internal marketing.

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, co pay 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 immediately. I authorize Desert Dentistry to keep my credit card on file and charge any over 90 day balance to it.** A call will be placed to my primary contact number prior to placing any charge.

_____ I authorize Desert Dentistry to use the credit card on file if due to insurance; a refund has accumulated on my account. A call will be placed to my primary contact number prior to crediting the card.

_____ I understand that any account balance generated is due. 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, must prepay in advance of treatment to receive a 5% discount)
- **Credit Card**
- **Patient Financing** (90 day INTEREST FREE loans and longer interest bearing loans are available)
- **Automated Credit Card Payments** (can be spread out over 3 months)

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 Party _____ Relationship to Patient _____

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|----------------------------------------------------------------------------------------------|
| Office use only: |
| Acknowledgement of receipt of our Notice of Privacy Practices could not be obtained because: |
| Individual Refused to sign: |
| Communication barriers prohibited obtaining acknowledgement |
| Other (Please Specify) |