Consent For Dental Treatment

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients dental or oral-facial needs including x-rays,study models,photographs, medications, and the use of local anesthetic agent.

Broken Appointment Policy

We realize that your time is valuable and we will strive to always run on time as to minimize waiting. Please give us 48 hours notice if you require a schedule change or cannot fulfill your commitment to the appointment. Repeated no shows or missed appointment will require that you pre-pay your appointment with credit or debit card.

_____ _____

Patient Signature (Parent of Child) Date

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your dental treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our Patient Information Form before seeing the Doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH,CHECK,VISA,MASTERCARD, DISCOVER & Amex

Regarding Insurance

As a service to our patients we will handle all insurance forms and bill your insurance company for you. Please have all your insurance information and original claim form. We are not responsible for knowing your Dental Insurance contract and what treatment they may not cover, your policy is a contract between you and your insurance company, we are not a party to that contract. However, the balance is your responsibility whether your insurance company pays or not. **We will help you with any claim disputes, but if your insurance company has not paid your account in full within 45 days, the balance of your account will be your responsibility.** Please be aware some and perhaps all of the services provided may not be considered reasonable and necessary under your dental insurance plan.

If you chose to carry a balance with us there is a monthly service charge of 1.5% or 18% a year. The patient will incur any collection charges if the account is sent to an outside agency.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

_____ _____

Spinelli Dental

Acknowledgment of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations

Acknowledgement and Consent

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of Patient/Person Responsible:_____

Print Name:_____

Date:_____

Names of Dependents who are patients here:

_____ _____

_____ _____

_____ _____