Consent for Services

Please initial after each statement acknowledging that you have read and agree to the contents. Thank you

I hereby authorize the doctor and/or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my child's dental condition(s). _____

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

I agree to the use of local anesthetics, sedatives, and other medications as necessary. I fully understand an anesthetic agent embodies certain risks. I have been given an opportunity to ask my questions regarding possible complications. ____

Financial Policy

Thank you for choosing our office as your dental care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service. We accept Cash, Personal Check, Visa, MasterCard, Discover, American Express, Debit Cards, and Care Credit patient financing. Please be aware that a $35.00 fee will be charged for all returned checks.____

If you do not have dental insurance, we will collect the amount due for services at each appointment. If you do have traditional dental insurance, we will do our best to confirm your coverage and you will be asked to pay only the **ESTIMATED** part of your bill at the time of service that we think your insurance will not cover. We will submit your claim to your insurance at no charge to you. We however, do not file secondary insurance that will be your responsibility. You will then have 21 days from the date of your statement to remit the remaining payment to us. A service charge of 1.5% per month (18% per annum) on the unpaid balance can be charged on all accounts 60 days or more past due. Further collection activity and credit reporting will be initiated on all 90 days or more past due balances **According to state law, your insurance carrier has 15 working days to pay your insurance claim. If after 30 days, they have not paid, then we will ask you for help in solving this.**

We **CANNOT** guarantee what your insurance company will pay; we simply estimate the amount most insurance companies pay based on most traditional plans. We can submit a pre-treatment estimate before any major work is started (crowns, bridges, implants, dentures, etc.) to your insurance company. All major dental work is required to be paid in full before cementation or delivery.____

Your insurance policy is a contract between you and your insurance company. You are our patient and we will treat you, not your insurance company. **If your insurance company has not paid your account in full within 60 days, the balance will be sent to you in the form of a statement**. You will then have 21 days from the date of your statement to remit payment to us. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the dental provisions of your insurance plan.____

I understand that the co-payment or patient portion of payment is only an **ESTIMATE** and I will be responsible for any balance after the insurance payments are made. ____

I understand that if sedation is to be administered during my treatment, there will be a pre-op visit to go over my treatment. Payment in full is required at my pre-op appointment. ____

I understand that any appointment over an hour in length will **REQUIRE** a 25% down payment at time of scheduling the appointment. The down payment will be forfeited if the appointment is cancelled with less than 48 hours notice.____

I understand that I will need to request in writing and pay a reasonable administrative fee if I want to have copies of my records. ____

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependant(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice and to be applied directly to any outstanding balance on my account. ____

Adult patients are responsible for payment at the time of service. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied, unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash at the time of service.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. ____

BROKEN APPOINTMENT POLICY: when you make your appointment, the doctors' and staffs' time is specifically reserved for you. When you cancel your appointment without giving us a 48 hour notice, the time we have reserved for your appointment cannot be replaced. Our office will charge and collect the full amount of your missed appointment fee of $25. ____

COFIRMING APPOINTMENTS: We do require for you to contact us through phone, email, or Revenue Well to confirm your appointment. If we do not hear from you at least 24 hours before your appointment we reserve the right to give that allotted time to another patient. ____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPS). I understand that by signing this consent, I authorize Gainesville Dental Group to use and disclose my protected health information to carry out the following:
1. Treatment including direct or indirect treatment by other healthcare providers involved in my treatment.

2. Obtaining payment from third-party payers (i.e. insurance companies).

3. The day to day healthcare operations of Gainesville Dental Group.

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and discloses of my protected health information, and my rights under HIPPA. I understand the Gainesville Dental Group reserves the right to change the terms of the notice from time to time and that I may contact Gainesville Dental Group at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. However, if the management of Gainesville Dental Group does not agree to these requested restrictions, then Gainesville Dental Group is not bound to comply with said restrictions.

I understand that I have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent form is not affected.

I have read and understand my consent to the use and disclosure of my protected health information.___

Please print the name of the person who has completed and signed this form:

_____

Signature of patient, parent or guardian (responsible party):

Signature: _____

Date: _____

Upon completion, please sign the forms at the front desk. Thank you!