SMILES BY DESIGN SAN DIEGO

Consent for Services

* I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my dependents dental needs.
* 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 anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications or risks.
* I give consent to the doctor or designated staffs use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for purpose of carrying out my treatment, payment and health care operations.
* As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
* All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
* Patients who carry dental insurance are responsible for the total fee. It is important that you give us the accurate information to process the insurance claims correctly (i.e. Social Security numbers, ID numbers, subscriber information). As a courtesy we will prepare all insurance claims and bill out services to your dental insurance provider. In the event the insurance company does not pay their portion within 60-days the patient or guardian is responsible for the total fee unpaid by the insurance carrier.
* Insurance companies do not guarantee payment until the services are rendered. We do our best to **ESTIMATE** your patient portion based on the information released to us from your insurance carrier.
* Patient portion/Co-Pay is DUE at the time services are rendered.
* With insurance companies we are contracted/ in-network with, the Insurance Fee's are SET by the insurance carrier. We have no control of the fee's YOUR insurance company assigns to our office. Please contact your insurance company or HR department for any additional questions.
* A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
* I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
* In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time 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.
* I acknowledge I have received a copy of the dental materials fact sheet dated May 2004 as required by state law.
* I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

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Signature Date

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign the acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

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Signature / Date

I, ______________________________ am the "personal representative" and have legal authority to make health care decisions about the following patient:

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Please print name here