SBD Dental Financial Policy & Consent for Services

Welcome to Dr Javaheri's office. We are dedicated to providing you with the very best dental care and services, as a result, your understanding of our financial policy is an essential element of your care and treatment. To assist you, we have the following financial policy. Please read it thoroughly. If you have any questions, please feel free to discuss them with our office staff.
Please initial each line item.

_____**We offer dental insurance billing as a courtesy to our patients.** You, the financially responsible party, agree that you are responsible for any and all charges for services rendered, should your insurance company fail to pay any portion of the claim(s) due to frequency limitations, exclusions,maximums, deductibles, age limitations, waiting periods, eligibility, termination or any other reason not listed you are 100% financially responsible. Benefits and eligibility are verified upon request from the patient. It is patient responsibility to provide us with accurate insurance benefit details including a copy of the insurance card if applicable, subscriber ID, birthdates, and any other information pertaining to acquiring insurance benefits. Insurance carriers only provide a Summary of dental benefits and not a guarantee of payment. This office cannot render services on the assumption that our charges will be paid by your dental insurance. If something is not covered on your insurance plan, it does not mean it was not necessary, it simply means it may NOT be a covered benefit on your particular dental plan. For benefit details about your plan please call your dental insurance company directly for the most accurate information.
I understand that Dental Insurance carriers cannot and do not diagnose treatment. The goal of dental insurance is to pay for the least expensive option for dental treatment not the best option for your health. Insurance carriers may downgrade their payments for procedures.

_____**Payment is due when services are rendered unless a prior payment arrangement has been made:** For your convenience, we accept Visa, MasterCard, Discover, and American Express credit cards; we also accept cash and check payments. Outside financing is available through Care Credit.

_____**A minimum Deposit of $50** is **required** to reserve your dental treatment appointment. In the event you cancel, reschedule or no show with less than 2 business days notice, you will forfeit your deposit and be required to pay a new deposit upon rescheduling.

_____**If you have dental insurance, we require your estimate portion (Patient's Portion) of your fee at or before the time service is to be rendered.** We will file a claim with your insurance company and you will be billed for any balance that remains after insurance has paid.

_____**If you are unable to keep a scheduled appointment, we require a 2-Business notice in order to allow another patient to benefit from that time.** Failure to let us know of your cancellation 2 Business in advance will result in a nominal charge of $50.00 per 60 minutes of scheduled appointment time.

_____**You, the financially responsible party, agree to pay for any collection fees, including legal or other services, necessary to collect overdue accounts.** There will also be a $50.00 charge for any returned check. Balances greater than 90 days past due will be turned over to a collections agency and assessed a $150-$500 penalty late fee, plus 18% interest on the outstanding balance.

_____**There is a $45 fee to copy/e-mail patient records, unless we are copying them for a specialist referral we have arranged.**

If you had the x-rays taken as a free promotional service (Get one free, or Groupon etc) and would like a copy, you are responsible to pay the full fee for the x-rays which are $110.00

I, (please print) _____, have read and understand the Patient Financial Policy for Smiles by Design San Diego.

Signed: _____ Date: _____ _____

Relationship to patient

Consent for Services & Standard of Care

* Standard of care is a legal concept that a dentist must meet and is the basic practices of highly regarded dentists who have comparable education and knowledge, who practice in similar disciplines and those who practice in a comparable area. The standard simply reflects that which is minimally required, meaning that anything less would be considered negligent.

Standard of care for our office is as follows:

- The doctor and hygienist recommend cleanings a minimum of 1 time every 6 months, regardless of insurance coverage.
- Doctor/Dentist requires x-rays be taken in order to be able to diagnose accurately.
- Dental X-rays are a very important diagnostic tool- We require at a **minimum** Full mouth x-rays are taken every 3 years, check-up x-rays are taken annually. We will accept digital x-rays from another office as long as they are less than 3 mo. old from the date taken
- Emergency/Limited Exam/Dental Treatment x-rays are taken as needed.

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor. 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 to make a thorough diagnosis of myself or my dependents dental needs.
I grant my permission to you or your assignee, to telephone, text e-mail me at home or at my work to discuss matters related to this form as well as to receive appointment reminders and confirmations.
I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I, (please print) _____, have read and understand the Consent for Services for Smiles by Design San Diego.

Signed: _____ Date: _____ _____

Relationship to patient