DEAN COSMETIC DENTISTRY CENTER

Advanced Technology in a Relaxing Environment

OFFICE POLICY CONSENT FORM

INSURANCE ASSIGNMENT

I certify that myself or my dependent is covered b dental insurance and assign directly to Donnie Dean DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use mine and/or my child's health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed.

INFORMED CONSENT

I am consenting for treatment for myself or I am the parent, guardian, or personal representative. There are no court orders now in effect that prohibits me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the patient named above, including but not limited to x-rays, and administration of anesthetics, and all dental procedures which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days from the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

MEDICAL HISTORY

To the best of my knowledge, the Medical History form has been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received or read a copy of the Dean Cosmetic Dentistry Notice of Privacy Practices.

MISSED APPOINTMENT FEE

Please remember that we have reserved this time especially for you. Therefore, we request at least a 24 hour notice in order to reschedule your appointment. A $44 fee will be charged to your account per missed appointment. This amount is not covered by insurance and is your responsibility.

Signature of Patient/Parent/Guardian _____ Date: _____

Signature of Dean Cosmetic Dentistry _____Date:_____