INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient (guardian), have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless or until you discuss potential benefits, risks, and complications with your dentists and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risk and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, your may increase the chances of a poor outcome.

Please read and initial items below and sign at the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:
Examinations, Preventive Services, Restorations, Crowns, Bridges or Other

Patient Initials **(guardian)**: _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissue: pain, itching, vomiting, and/or anaphylactic shock
(severe allergic reaction).

Patient Initials **(guardian)**: _____

3. Changes in Treatment 0Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials **(guardian)**: _____

I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

_____ _____

Signature **Date**

Written Financial Policy

Thank you for choosing Perfect Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Check, Visa, Master Card, American Express, Discover Card, Care Credit[1] or Lending Club[1]
- Perfect Dental Payment Plan[2]
    - Available for Treatment Plans over $500
    - Automatic weekly/monthly billing to your credit/debit card
    - Allow you to pay over time
    - No annual fee

Perfect Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care provided and lab fees.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

Perfect Dental charges $35 for returned checks and $25 for accounts sent to collections.[4]

You grant permission to us or our assignee, to telephone you to discuss this statement or your treatment.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of patient examination.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for at the time services are provided unless other arrangements are made.

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.

If you have any questions, please do not hesitate to ask.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]Payment Plan must be paid in full before completion of services.

[3]However, if we do not receive payment from your insurance carrier within 60 days or after we make 3 attempts, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

[4]If your account balance is not settled at the time of appointment, our office will invoice you for the balance on a monthly basis for up to 3 invoices. Any account that is over 90 days past due will be assigned to a collection agency for further billing.

Revised 07/31/2017

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

I, _____ have received a copy of this office's privacy practices

Please print name

_____ _____

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but **acknowledgement could not obtained because:**

____ Individual refused to sign

____ Communication barrier prohibited signing the acknowledgement

____ An emergency situation prevented from us obtaining acknowledgement

____ Other (please specify)

_____

_____