The Center for Cosmetic and Sedation Dentistry

Our staff is committed to providing you with the very best possible care! With your assistance and understanding we can share a mutual respect that will lead to a long lasting relationship. In order to achieve this goal, we would like to make you aware of our office policies.

We make every effort to explain your treatment needs and costs to you up front so that we can avoid any misunderstandings. If you have any questions, please do not hesitate to ask. We are here to serve you.

1. Payment is due at the time services are rendered unless prior payment arrangements have been approved by our staff. We accept cash, check, MasterCard, Visa, American Express, Discover, Carecredit and Springstone Financial. There will be a 6% return fee for all financing, if the return is not requested within 30 days. Emergency visits for all new patients must be paid in full unless dental insurance can be verified.
2. Payment is due at pre-op appointment for all sedation appointments.
3. Our staff will estimate your co-pay for each visit and this amount will be due at the time of service. Estimates of insurance payments are guidelines only. We can make no guarantee of the insurance payment(s) estimated. Dental insurance is a contract between a patient/guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the incurred charges.
4. Formal collection action will be initiated for all balances over 60 days that do not have prior financial arrangements. You will be responsible for any collection charges that are incurred.
5. Balances older that 60 days will be subject to an interest charge of 1.5% per month until balance is paid in full.
6. I authorize and direct payment of the dental benefits directly to The Center for Cosmetic and Sedation Dentistry and consent to disclosure of my protected dental health information to carry out payment of benefits.
7. ANYONE MISSING OR CANCELLING AN APPOINTMENT WITH LESS THAN A 48 HOUR NOTICE WILL BE SUBJECT TO A CHARGE OF $50 OR 10% OF THE SCHEDULED AMOUNT.
8. **If broken appointments become a chronic problem, we reserve the right to dismiss you from the office.
9. * Saturday appointments **must** have a 48 hour cancellation notice to avoid cancellation fees. All Hygiene appointments will be $75 and a Restorative appointment will result in a $250 if no showed or cancelled without the proper notice.

I have read, understood and accept the terms stated above. I have been given a copy of this document.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.
As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.
You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this Consent Form after you have signed it.

E-Mail Consent:
I wish to communicate via e-mail with Cosmetic and Sedation Dentistry on matters related to my health and/or my medical treatment. I understand that any confidential health information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail. I also understand that is not the policy of the practice to encrypt any confidential health information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge the risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.
Please print your name_____
Signature _____
Date _____