Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the cost incurred in the 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 arrangements, must be paid for at the time of service.

A service charge and/or statement fee may be assessed on unpaid balances on all accounts extending 60 days.

I understand that Treatment Plan estimate fees listed for dental care can only be extended for a period of 6 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 the responsible value of said services to said Doctor, or their assignee, at the time said services are rendered or within five (5) days of billing, if credit should be extended. I further agree that the responsible value of said services shall be billed unless objected to, by me in writing within the time for payment thereof, I further agree that a waiver of any breech of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and responsible attorney fees if suit be instituted hereunder.

If at any time it becomes necessary to assign your outstanding balance, to an outside collection agency or attorney for collections of monies owed to Let’s CU Smile Dentistry. You the patient/guarantor agree to pay the principle balance owed and all related collection fees and/or legal costs and fees.

I grant my permission to you or assignee, to telephone me at work or at my home to discuss matters related to this form.

Please sign Signature Form for your consent.

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review the Let’s CU Smile Dentistry’s HIPPA Notice of Privacy Practices:

It tells me how Let’s CU Smile Dentistry will use my health information for the purpose of my treatment, payment for treatment and health care operations

It explains in more detail how Let’s CU Smile Dentistry may use and share my health information for other than treatment, payment and health operations.

Let’s CU Smile Dentistry will also protect, use and share my health information as required/permitted by law.

Please sign Signature Form for you consent

Signature Form

Health History - To the best of my knowledge, the questions on the health history form have 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.

Signature of Patient, Parent or Guardian Date

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Consent for Services – I have read the Consent for Services and Financial Policy and agree to their content.

Signature of Patient, Parent or Guardian Date

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Privacy Practices – I acknowledge that I have read a copy of the Let’s CU Smile Dentistry’s Notice of Privacy Practices and that I may request a copy of this notice at any time.

Signature of Patient, Parent or Guardian Date

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Referral Information – Whom may we thank referring you to our practice?

\_\_\_\_\_Another patient, friend or relative \_\_\_\_\_Dental office \_\_\_\_\_Advertisement

\_\_\_\_\_Internet Name of referring person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_