Please print and sign then bring completed forms to your appointment.

CREST DENTAL GROUP OF VALENCIA

## Patient Information

Patient Name: Last _____ First _____ MI _____ Date:_____

○ Male ○ Female ○ Married ○ Single ○ Child Other _____

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Age:_____

Cell Phone #: (_____) _____-_____ Work #: (_____) _____-_____ ext _____ Home #: (_____) _____-_____

Preferred Method of contact: ○ cell ○ text ○ email ○ home ○ work

Email Address: _____ Drivers License # _____ State _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Phone #: (_____) _____-_____ Employer: _____

How did you hear about our office: _____

## Medical History

Are you under a physician's care now? ○Yes ○No
Have you ever been hospitalized or had a major operation? ○Yes ○No
Have you ever had a serious head or neck injury? ○Yes ○No
Are you taking any medications, pills or drugs? ○Yes ○No
Please list : _____

Do you take or have you taken; Phen-Fen or Redux? ○Yes ○No
Have you ever taken Fosomax, Boniva, Atonel or any other medication containing bisphosphonates? ○Yes ○No
Are you on a special diet? ○Yes ○No
Do you use tobacco? ○Yes ○No
Do you use controlled substances? ○Yes ○No

Please explain any "Yes" answers from above : _____

Physician's name: _____ Physician's Phone # : (_____) _____-_____

Are you allergic to any of the following? ☐ Amoxicillin/Penecillin ☐ Erythromycin ☐ Cefin, Ceclor, Keflex ☐ Asprin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drug ☐ Other Allergy _____

Women, Are You: Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Please check all that apply:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ○Yes ○No | Cortisone Medicine ○Yes ○No | Hemophilia ○Yes ○No | Radiation Treatments ○Yes ○No |
| Alzheimer's Disease ○Yes ○No | Diabetes ○Yes ○No | Hepatitis A ○Yes ○No | Recent Weight Loss ○Yes ○No |
| Anaphylaxis ○Yes ○No | Drug Addiction ○Yes ○No | Hepatitis B or C ○Yes ○No | Renal Dialysis ○Yes ○No |
| Anemia ○Yes ○No | Easily Winded ○Yes ○No | Herpes ○Yes ○No | Rheumatic Fever ○Yes ○No |
| Angina ○Yes ○No | Emphysema ○Yes ○No | High Blood Pressure ○Yes ○No | Rheumatism ○Yes ○No |
| Arthritis/Gout ○Yes ○No | Epilepsy or Seizures ○Yes ○No | High Cholesterol ○Yes ○No | Scarlet Fever ○Yes ○No |
| Artificial Heart Valve ○Yes ○No | Excessive Bleeding ○Yes ○No | Hives or Rash ○Yes ○No | Shingles ○Yes ○No |
| Artificial Joint ○Yes ○No | Excessive Thirst ○Yes ○No | Hypoglycemia ○Yes ○No | Sickle Cell Disease ○Yes ○No |
| Asthma ○Yes ○No | Fainting Spells/Dizziness ○Yes ○No | Irregular Heartbeat ○Yes ○No | Sinus Trouble ○Yes ○No |
| Blood Disease ○Yes ○No | Frequent Cough ○Yes ○No | Kidney Problems ○Yes ○No | Spina Bifida ○Yes ○No |
| Blood Transfusion ○Yes ○No | Frequent Diarrhea ○Yes ○No | Leukemia ○Yes ○No | Stomach/Intestinal Disease ○Yes ○No |
| Breathing Problem ○Yes ○No | Frequent Headaches ○Yes ○No | Liver Disease ○Yes ○No | Stroke ○Yes ○No |
| Bruise Easily ○Yes ○No | Genital Herpes ○Yes ○No | Low Blood Pressure ○Yes ○No | Swelling of Limbs ○Yes ○No |
| Cancer ○Yes ○No | Glaucoma ○Yes ○No | Lung Disease ○Yes ○No | Thyroid Disease ○Yes ○No |
| Chemotherapy ○Yes ○No | Hay Fever ○Yes ○No | Mitral Valve Prolapse ○Yes ○No | Tonsillitis ○Yes ○No |
| Chest Pains ○Yes ○No | Heart Attack/Failure ○Yes ○No | Osteoporosis ○Yes ○No | Tuberculosis ○Yes ○No |
| Cold Sores/Fever Blisters ○Yes ○No | Heart Murmur ○Yes ○No | Pain in Jaw Joints ○Yes ○No | Tumors or Growths ○Yes ○No |
| Congenital Heart Disorder ○Yes ○No | Heart Pacemaker ○Yes ○No | Parathyroid Disease ○Yes ○No | Ulcers ○Yes ○No |
| Convulsions ○Yes ○No | Heart Trouble/Disease ○Yes ○No | Psychiatric Care ○Yes ○No | Venereal Disease ○Yes ○No |
| | | | Yellow Jaundice ○Yes ○No |

## Dental History

Reason for Today's Visit: _____

Date of Last Checkup/X-Rays: _____/_____/_____ Former Dentist: _____ Phone #: (_____) _____-_____

Check if you've had any problems with the following?

| | | | | |
|---|---|---|---|---|
| ☐ Bad Breath | ☐ Food Collection Between Teeth | ☐ Loose or Broken Teeth | ☐ Jaw Pain | ☐ Sensitivity to Sweets |
| ☐ Bleeding Gums | ☐ Sores or growth in your mouth | ☐ Periodontal Treatment | ☐ Snoring | ☐ Sensitivity When Biting |
| ☐ Grinding Teeth | ☐ Clicking or Popping Jaw | ☐ Sensitivity to Cold | ☐ Sensitivity to Hot | ☐ |

How often do you floss?_____ How often do you brush?_____ Are you fearful of dental treatment?_____

## Spouse or Responsible Party Information

CREST DENTAL GROUP OF VALENCIA

The following is for: ☐ The patient's spouse ☐ The person responsible for payment

Name: Last _____ First _____ MI _____ Date:_____

◯ Male ◯ Female ◯ Married ◯ Single Other _____

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Best time to call: _____

Cell Phone #: (_____) _____-_____ Work #: (_____) _____-_____ ext _____ Home #: (_____) _____-_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____

## Insurance Information - Primary

Is insured a patient? ☐ Yes ☐ No

Name of Insured: Last _____ First _____ MI _____

Insured's Birth Date: _____/_____/_____ Social Security #: _____-_____-_____ Group #: _____

Insured's Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child Other_____

Insurance Plan Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

## Insurance Information - Secondary

Is insured a patient? ☐ Yes ☐ No

Name of Insured: Last _____ First _____ MI _____

Insured's Birth Date: _____/_____/_____ Social Security #: _____-_____-_____ Group #: _____

Insured's Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child Other_____

Insurance Plan Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

## Consent for Services and Financial Responsibility

We are committed to your dental care being sussessful. Please understand that payment for your care is considered part of that care. Please read the following information carefully. We ask that you read, agree to and sign prior to any treatment.

- All patients must complete our patient information form before receiving treatment.
- Full payment is due at the time of serfvice unless previous arrangements have been made.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the pateint's account. We will complete the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges wull be paid by an insurance company.
- Estimated co-pay and deductibles is due at the time of service.
- We accept cach, check, Visa, MasterCard, American Express and Discover Card.
- We offer an extended payment plan (Care Credit) with prior credit approval.

**If Your Dental Insurance Does Not Pay, YOU ARE RESPONSIBLE.**

- There will be a charge for appointments missed without 24 hours notice.

Please let us know if you have any questions or concerns regarding this information.

## Signatures

**I have read the above conditions of treatment and payment and agree to their content**

_____ Date: _____ Relationship to Patient _____

Signature of patient, parent of guardian

_____ Date: _____ Relationship to Patient _____

Signature of guarnator of payment/responsible party

Crest Dental Group of Valencia

# HIPAA-REQUEST FOR RELEASE of RECORDS

**Crest Dental of Valencia**
**28212 Kelly Johnson Parkway Suite #170**
**Valencia, CA 91355**
**(661) 257-6453**
**FAX (661) 257-6450**

**This letter is a notice to:** _____

_____

_____

_____

**REQUESTING RECORDS FOR:** _____
**a patient of record at Crest Dental of Valencia.**

***Please release the x-rays, periodontal charting, and notes to our office at the above address as soon as possible to aid in providing our patient with the proper dental care.***
***Thank you for your help in this matter.***

***The signature below is an acknowledgement that the patient is giving Crest Dental of Valencia permission to request records from the previous doctor and authorizing the previous doctor to release the records to Crest Dental of Valencia.***

***Please send documents via email to info@crestdental.com or you may send actual paper documents which we will scan into our paperless system.***

_____
Printed Name

_____
Signature

_____
Date

**Crest Dental of Valencia**
**28212 Kelly Johnson Parkway Suite #170**
**Valencia, CA 91355**
**(661) 257-6453**
**FAX (661) 257-6450**

***Due to HIPAA regulations, we cannot discuss our patient's treatment or finances with anyone but the patient or their assigned representative.***

**I_____, authorize Crest Dental of Valencia's office to discuss my treatment plan and/or finances with my representative:**

_____

_____ _____
Patient's Signature Date

_____ _____
Patient's Representative Date

Crest Dental of Valencia
28212 Kelly Johnson Parkway Suite #170
Valencia, CA 91355
(661) 257-6453
FAX (661) 257-6450

# HIPAA INFORMATION and CONSENT FORM

The Health Insurance Portability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected health information (PHI). Their restrictions do not include normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically included the sharing of information with other health care providers, laboratories, health insurance payers as it is necessary and appropriate for your care. Patient files may be stored in open racks and will not contain any coding which identifies a patient's condition of information with is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examinations room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents of information.

2. It is the policy of this office to remind patients of their appointments. We may do this be telephone, email, U.S. mail, or by any means convenient for the practice and/or requested by you. We may send you other communication informing you of changes to office policy and new technology that you might find valuable of informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the performance of their duties.

5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager of the doctor.

6. Your confidential information will not be used for the purpose of marketing of advertising of product, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to the request.

I, _____ Date_____

do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information for and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Crest Dental Group of Valencia

# GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE
I understand that I am having the following work done: Exam, X-rays, Prophylaxis (Cleaning), and Other _____
X (Initials _____ )

2. DRUGS AND MEDICATION
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. X (Initials _____ )

3. CHANGES OF TREATMENT PLAN
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 discovered during examination. For example, root canal therapy following routine restorative procedures.
X (Initials _____ )

4. REMOVAL OF TEETH
Alternatives to removal of teeth have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the following teeth _____ and any other necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all of the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesis) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
X (Initials _____ )

5. CROWN, BRIDGES AND CAPS
I understand that no guarantee had been given that the proposed treatment will be to my complete satisfaction. I understand that sometimes it is not possible to match the color of natural teeth. I further understand the I may be wearing temporary crowns, which may come off easily and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying cementation. I understand that in some instances a root canal may be necessary during or after a crown or bridge procedure. X (Initials _____ )

6. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment, and hat occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand the endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.
X (Initials _____ )

7. PERIODONTAL LOSS (TISSUE AND DONE):
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions, and I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition.
X (Initials _____ )

8. FILLINGS
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. I understand that if a filling fails, a crown or alternative treatment may be necessary. X (Initials _____ )

9. DENTURES
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placements of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted denture(s). If a remake is required due to my delays of more than 30 days, there will be additional charges. X (Initials _____ )

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient or Guardian _____ Date _____

# INFORMED CONSENT FOR DENTAL TREATMENT

## CROWNS – CAPS

BENEFITS:
- Make you look nicer (cosmetic)
- To Repair a tooth which is badly broken
- To Prevent a tooth from fracturing
- To restore a tooth which has broken
- To eliminate a space where food is being trapped
- To hold a false tooth in place as part of a bridge
- To make a solid structure to attach partial denture
- To splint loose teeth together to strengthen them
- The tooth can no longer be filled

POSSIBLE COMPLICATIONS:
- Porcelain portion of crown may fracture
- Crown may come off and need to be reconnected
- Tooth may abscess and require further treatment (may not show up until later)

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Tooth will probably fracture
- Tooth may need to be extracted
- May need a root canal in addition to the crown
- May need bridgework or denture

ALTERNATIVES
- Extraction
- Temporary crown
- Steel crown

## BRIDGEWORK

BENEFITS:
- Make you look nicer
- To replace missing teeth
- Missing teeth are not removable
- Some of the same advantages as crowns
- Can improve chewing efficiency

POSSIBLE COMPLICATIONS:
- Same as crowns

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Teeth will drift and lean over
- May loose back teeth due to shifting
- Periodontal problems (Gun disease)
- Can reduce chewing efficiency

ALTERNATIVES:
- Partials
- Temporary partials
- No teeth in the spaces

## PARTIALS (REMOVABLE BRIDGEWORK)

BENEFITS:
- Cost

POSSIBLE COMPLICATIONS:
- Can wear on teeth
- Can rock or stress teeth – may loosen own natural teeth
- Metal clasps a sometimes visible
- Decay can occur under clasps
- Usually some amount of movement from the partial

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Same as under Bridgework

ALTERNATIVES:
- Bridgework
- Temporary Partial
- Keep spaces without teeth placement

## ROOT CANAL

BENEFITS:
- Eliminate decay
- Relieve Pain
- Save the tooth

POSSIBLE COMPLICATIONS
- Undiagnosable root fracture means failure and extraction
- Undiagnosable auxiliary canal means failure and extraction

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Extraction of tooth

ALTERNATIVES
- Extraction
- Bridgework

## FILLINGS

BENEFITS:
- Eliminate decay
- Relieve pain
- Fill in a hole or space in tooth
- Cover eroded area
- Protect a sensitive surface

POSSIBLE COMPLICATIONS:
- Tooth may abscess from the filling
- May fracture the tooth
- Tooth will be sensitive to temperature changes
- Toxicity from silver fillings is alleged by some
- Filling may fall out

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- May loose tooth
- Tooth may fracture
- Decay will get worse
- May result in need for root canal

ALTERNATIVES:
- Temporary filling

## GUM SURGERY (Gingivectomy)

BENEFITS:
- Eliminate infection
- Reduce food pockets around teeth
- Eliminate foul odors
- Reduce overgrown tissue
- Can eliminate Tartar effectively

POSSIBLE COMPLICATIONS:
- May need to be replaced after a time
- Some after-pain
- Might lose teeth if they don't respond to treatment

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Will lose tooth sooner
- May not get rid of infection

ALTERNATIVES:
- More frequent appointments for scaling

## EXTRACTIONS

BENEFITS:
- Last resort for non-salvageable tooth
- Eliminate pain
- Remove teeth that are out of position

POSSIBLE COMPLICATIONS:
- Fractured particles may remain
- Irritation to nerves may cause temporary or permanent numbness
- Part or all of the tooth may be lodged in sinus, requiring more surgery
- Bad infections may take a long time to clear up
- Jaw may be stiff and difficult to open for a time
- If jawbone is very weak it may fracture

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Spread of infection
- Swelling
- Pain

ALTERNATIVES:
- None

## CLEANING – SCALING

BENEFITS:
- Look nicer
- Clean mouth
- Eliminate odors
- Prevent odors
- Prevents Gum Disease
- Some portions may be performed by auxiliary personnel

POSSIBLE COMPLICATIONS:
- Sensitive teeth
- Feeling of spaces between teeth
- Filling may be loosened (Normal if filling was ready to fall out)
- Sensitive gums

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Stains on teeth
- Odors
- Gum Disease
- Will lose teeth sooner

ALTERNATIVES:
- None

## X-RAYS

BENEFITS:
- More complete diagnosis
- Can find hidden problems
- Can make a determination of treatment
- X-Rays are taken by qualified personnel

POSSIBLE COMPLICATIONS:
- Exposure to X-Ray radiation (minimal)
- X-ray pictures remain property if this office

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Cannot perform dental services

ALTERNATIVES:
- None

## BONDED FACINGS

BENEFITS:
- Esthetics – they look really nice
- Cover crooked teeth
- Close spaces and gaps
- Cover discolored teeth

POSSIBLE COMPLICATIONS:
- Edges can stain after a time and need to be freshened up (additional fee)
- Breakage can occur, resulting in need for remake
- Difficult to remove

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- None (other than appearance)

ALTERNATIVES:
- Crowns

## LOCAL ANESTHETICS

BENEFITS:
- Avoid pain during treatment and procedures

POSSIBLE COMPLICATIONS:
- Prolonged numbness may extend beyond normal
- Nerve damage
- Bruising (hematoma)
- In rare instances, possible consequences may include all of those applicable. General Anesthesia, including allergic reactions up to and including death

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Mild to severe pain during and after treatment

ALTERNATIVES:
- Willingness to accept pain during treatment

Name of Patient _____

I have read the above statements and have received a copy of them if requested, and recognize their importance in helping me make decisions. My initials indicate that I have read and understand this consent document. I recognize that failures can occur for all kinds of reasons and that complications can occur in any procedure. I also understand that, where decay has occurred, or a tooth has fractured or abscessed, that these same forces are still working on the tooth even after it has been restored therefore, decay or fracture can still occur as the restored tooth is not better than what nature has given in the first place. If for any reason a conflict or disagreement should arise I will present such conflict or disagreement to my attending dentist in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation/mediation board such as the dental society and agree to accept their resolution in lieu of pursuing remedies by way of litigation. I also understand that this agreement is binding on my heirs and all other family members. I now give my consent to the attending dentist to render to me dental treatment that we have agreed is necessary for myself. I also agree to reimburse the attending dentist for all services rendered to me and I am aware that the payment for these services is due at the time they are rendered.

Signature _____ Date _____

## Financial Policy

Crest Dental Group of Valencia

This is an agreement between Crest Dental of Valencia (hereafter referred to as 'us') and the patient (hereafter referred to as 'you') named on this form. By signing this agreement, you are agreeing to pay for all services received in this office.

**Payment Options If You Have No Insurance**: You may pay by cash, check or credit card on the date that treatment is provided, or any date thereafter as agreed upon by us.

**Payment Options If You Have Insurance:** We ask that you pay your deductible and any out-of-pocket portions, if not met at **the time services are rendered** by cash, check or credit card. **Ultimately you are responsible for your deductible as well as any out-of-pocket portions and you will need to pay for services done that were not paid from your insurance.**

**Co-payments**: Any co-payments required by an insurance company must be paid at the time of service.

**Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility.**

**Non-contracted insurance:** Insurance is a contract between you and your insurance company. We Are NOT a party to this contract. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination about your eligibility and the amount they will pay based on THEIR scheduled fee. In the end, you agree to pay any portion of the charges not covered by your insurance.

**Statements:** If you have a balance on your account, we will send you a statement, showing the payment due on the enclosed statement. Unless other arrangements have been approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Late Charges:** A late payment fee of $25 will be added to your balance if the payment due is not received within 60 days of the statement date.

**Finance Charges:** A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. In the event that your account is not paid and we refer to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs and collection agency fees).

**Bounced Check Fee: Any check that is bounced/returned, you will be charged a $35 fee to your account.**

**Changes to your insurance or address:** It is your responsibility to advise us if there are any changes to your insurance or your address. Any denials by your insurance company resulting from failure to advise us of cancellations and/or changes will become your responsibility to pay.

**Payments made directly to you by your insurance company:** In some instances, you may receive payment directly from your insurance company for services provided in our office. It is your responsibility to either endorse the check to us or to issue your own payment for the same amount you received. PLEASE NOTE THAT THIS PAYMENTS IS NOT FOR YOU AND FAILURE TO PAY US MAY RESULT IN LEGAL ACTION AGAINST YOU.

**Collections/Past Due Accounts:** If you fail to pay any amounts owed by you despite repeated efforts made by us to collect from you, we may choose to send your account to a collection agency for collection. Any collection charges incurred by us will be added to your account balance.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation , the parent authorizing treatment for a child will be the parent responsible or those subsequent charges. If the divorce decree requires that other parent to pay all or par of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**FOR YOUR CONVENIENCE WE ACCEPT CASH, VISA, MASTERCARD**

I have read all of the above and agree to the terms set therein.

Patient's Name: _____ Responsible Party: _____
(If not the patient)

Signature: _____ Signature: _____

Date: _____