Laurelwood Family Dentistry™

New Patient Consent for Treatment and Practice Policies

Directions: Please read and initial next to every number stating you understand our office policies.

_____ **1.** I understand that I will notify the practice if my address, phone number(s), email address, dental or medical benefit carrier information has changed prior to the beginning of every appointment.

_____ **2.** I understand that I will be given a written comprehensive treatment plan whenever any treatment is recommended by the doctor. If treatment is extensive, the plan will be divided and given to the patient in two parts. The first part will be Phase I therapy to increase the patient's health (i.e. remove disease). The second part will be Phase II therapy to restore function and aesthetics (i.e. implants, bridges, veneers, partial dentures…).

_____ **3.** I understand that by signing the recommended treatment plan the patient has no obligation to this practice to complete the recommended treatment within this practice. The patient's signature is confirmation that oral and systemic (i.e. whole body) health problems are present and need to be resolved for optimal oral and systemic health.

_____ **4.** I understand that if I reserve and / or confirm an appointment with the dental hygienist and / or the doctor and then break the appointment within less than forty-eight (48) business hours of verbal notice, show up later than fifteen (15) minutes or do not show up this will be considered a broken appointment. A fee of eighty-five dollars ($85.00) will be charged to your account and a fifty percent (50%) deposit will be required to reserve any future appointment(s). Saturday broken appointments will accrue a fee of one-hundred dollars ($100.00).

_____ **5.** I understand that if a second (2nd) broken appointment occurs a fee of eighty-five dollars ($85.00) will be charged to your account. You will only be allowed to reserve an appointment the same day that you call, if our schedule allows, for the requested same day appointment.

_____ **6.** I understand that if a third (3rd) broken appointment occurs you will be dismissed from the practice as we will no longer be able to provide uniform and consistent care for you. The practice is still available for emergency treatment for the next 30 days while you are seeking care with another practice.

_____ **7.** I understand that rude behavior, violence (verbal and physical), unruly activity, racism, sexual harassment and profanity will not be tolerated. These actions will be grounds for immediate dismissal from this practice.

_____ **8.** I understand that if I am a relative, caregiver or emancipated minor I must provide legal documentation authorizing the relative, caregiver or emancipated minor the right to consent to treatment.

_____ **9.** As a professional courtesy, all personalized treatment is guaranteed for one (1) year from any manufacturer's material(s) failure(s) or defect(s). If a patient only desires to complete a portion of the doctor's recommended treatment this ***guarantee will be null and void*** as the recommended treatment is inclusive for all treatment to function together properly as an entire unit.

_____ **10.** If a prosthetic (i.e. crown, onlay / inlay, night guard, denture and / or partial denture) is a part of the treatment then all post-operative adjustments will be done free of charge for the first ninety (90) days after the delivery. After ninety (90) days fees will apply.

_____ **11.** I hereby acknowledge that I have read and received a copy of the Notice of Privacy Policy for Laurelwood Family Dentistry. This notice describes how health information about the patient is used and disclosed. This notice also describes how you can have access to this information upon request.

Please turn the page over →

Laurelwood Family Dentistry™

Financial Policy and Consent for Treatment

Directions: Please read and initial next to every number stating you understand our office policies.

_____ **12.** I understand that payment (i.e. fee, deductible, co-pay and / or co-insurance) is due the day treatment is rendered. Our services are provided directly to you the patient and not to a medical insurance or dental benefit policy.

_____ **13.** I understand that statements for any unpaid balances will be mailed to the patient at thirty (30) and sixty (60) day intervals. Any unpaid balance will be sent to a collection agency after sixty (60) days. The patient will then be dismissed from the practice for not fulfilling their financial obligation for treatment rendered. Unpaid balances will include an eighty-five dollars ($85.00) collection agency fee.

_____ **14.** I understand that my records are the possession of the practice (NC Statute: 21 NCAC 16T .0102). The patient has the legal right to request their records at any time as described in the Notice of Privacy Practices. Due to Health Insurance Portability and Accountability Act of 1996 the patient's written and signed consent to duplicate records will be required. All records will be provided to the patient within a reasonable timeframe based upon the extent of the request and applicable state law of thirty (30) days. *This request is conducted on our administrative days (i.e. Monday).* A nominal administrative charge may be charged based upon the extent of the records request. The fee will be required for the time and effort of the staff member(s) to assemble the specific requested records and contact any 3rd party vendors. The patient can immediately fulfill the fee or be billed for this service.

_____ **15.** The treatment plan demonstrates an ***estimation*** of your medical and / or dental benefits coverage. Our practice has no control over what can and cannot be covered in an individual dental, medical or surgical benefit policy. A dental, medical or surgical benefit policy coverage is a financial agreement between a patient and the company they have purchased the policy from. The patient has the full and ultimate responsibility of payment for any deductible, downgrade, non-covered procedures or co-insurance dictated by the dental, medical or surgical benefit carrier and policy. The patient has the ultimate responsibility to understand the dental, medical or surgical benefit policy they have purchased and accepts responsibility for the full amount of charges incurred for their oral health treatment.

_____ **16.** Professional healthcare services are rendered to you and ***not*** your dental, medical or surgical benefit carrier. ***As a courtesy***, our practice will submit a claim to a dental, medical or surgical benefit carrier for reimbursement of your professional healthcare services. You the patient assign payment for these entitled benefits to our practice along with a release any information required from a dental, medical or surgical benefit carrier regarding the illness and treatment(s). If the patient's dental, medical or surgical benefit carrier does not pay for the filed claim within ninety (90) days the balance then becomes the patient's sole responsibility. You also affirm that any payment made directly to the patient from a dental, medical or surgical benefit carrier will be immediately transferred to our practice. A photocopy, scan or facsimile of this assignment is to be considered as valid as the original for a lifetime unless otherwise indicated in writing.

_____ **17.** Fee-for-service and non-contracted PPO ***estimated*** fees are valid for thirty (30) days. Contracted fees may change at any time at the sole discretion of the patient's dental, medical or surgical benefit carrier. This practice has no control over contracted fees or policy coverage. All of the ***estimated*** cost(s) for treatment will be fully discussed prior to treatment being rendered.

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_____ **18.** Not all dental, medical or surgical benefit plans cover certain services to restore your oral and systemic health. In the event the policy you have chosen to purchase determines a service to be "not covered," you will be responsible for the complete fee. These non-covered services will be discussed with the patient before they are rendered if the medical and / or dental benefits carrier properly notifies us of such an event.

_____ **19.** Laurelwood Family Dentistry accepts cash, personal check, debit cards, credit card (Visa, MasterCard, American Express and Discover), PayPal, Lending Point and Care Credit™. We will keep your credit card information in our encrypted computer network. Nominal unpaid balances of one-hundred dollars ($100.00) or less will be automatically charged. If you do not consent, then a ten (10%) percent interest fee will be applied to your account every thirty (30) days towards the unpaid balances until the account is fulfilled.

_____ **20.** For all reserved appointments with the doctor or treatment with the registered dental hygienist, a twenty-five percent (25%) deposit is ***required***. This deposit will be applied to the overall cost of the treatment. If the appointment is cancelled with less than forty-eight (48) hours of verbal or written (email / text) notice or the patient does not show up ***the deposit will be forfeited in its entirety.***

_____ **21.** For Saturday appointments, pre-payment in full is ***required*** to reserve your appointment. If the appointment is cancelled at any time or you do not show up ***the pre-payment will be forfeited in its entirety and a refund will not be issued.*** The patient will only be allowed to schedule future appointments during normal weekday clinical hours.

_____ **22.** Laurelwood Family Dentistry charges an eighty-five dollar ($85.00) administrative fee for each returned personal check(s). Once the personal check is returned, no further personal checks will be accepted. All future payments must be made with a credit card or cash.

Please do not hesitate to ask the doctor or team any questions as we are here to help you receive the best care you need and deserve. By signing the consent for treatment and practice policies, you verify that you have asked our doctor and / or team all questions regarding additional information needed to fully understand the previous statement(s). You also consent for this practice to treat your oral healthcare needs and have the legal right to do so for yourself or for the patient if they are less than 18 years of age, an emancipated minor or incapable of making decisions regarding their health care (caregiver). We greatly appreciate the opportunity to help you achieve all your oral healthcare needs.

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Patient's Name: (Please print)

_____ _____

Patient's Signature: **Today's Date:**

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Guardian's Signature: (If the patient is less than 18 years of age or with a caregiver)

Personal Representative: (Please Circle) **Guardian** **Healthcare Power of Attorney**