Patient's Name (Print): _________________________________ Patient's DOB: ________________

Consent for X-rays and Photographs

I understand that radiographs and photographs will be necessary to properly diagnose any dental disease, such as decay and gum problems. Dental photography may also be used for treatment planning and recording of pre-treatment and post-treatment results. I hereby give permission for the staff Smile Dental to take necessary radiographs and photographs. I understand that these records will become part of my personal dental file and may be used for communicating with laboratories, insurance companies, referring dental offices, or as a teaching aid.
Initial (_____________)

Smile Dental Financial Policy

General- Thank you for choosing our practice as your dental care provider. We are committed to our treatment being successful. Please understand that payment of our bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our New Patient Medical History Form, HIPAA, and Consent for x-rays and Photographs form prior to seeing the Doctor. Patient portions are due at the time of service in full unless prior arrangements have been made. **Initial (____________)**
WE ACCEPT CASH, CHECK,VISA,MASTERCARD,DISCOVER AND CARECREDIT.

Please read and initial.

(_____) Regarding Insurance- Fees are estimates only and are valid for 6 months from the date shown and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any changes in treatment.

(______) Regarding Insurance plans where we are a participating Provider- ALL ESTIMATED portion and deductibles are due at time of treatment. If YOUR insurance coverage changes to a plan that we are non-participating providers in, it is your responsibility to notify us of the change prior to your appointment, and you will be responsible for any and all fees not paid by YOUR insurance.

(______) Usual and Customary Rates- Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. YOU are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

(______) Adult Patients- Adult patients are responsible for FULL payment at time of service.

(______) Minor Patients- The adult accompanying a minor and the parents (or guardian) are responsible for full payment. Any unaccompanied minor with a non-emergency treatment will not be seen unless charges have been pre-authorized to be approved with the card information, or a payment of cash or check is with the minor.

(______) Missed Appointments- Unless appointment is Cancelled at least 2 business days (Mon-Thur) in advance, there will be a missed appointment charge at the rate of $25 up to the full amount of the scheduled appointment that will be charged to your account. Future appointments will not be scheduled until this charge is paid in full.

(______) Deposits- There may be appointments that will require a deposit be paid in advance to schedule the appointment. This deposit will be a credit on your account and will be applied to the services on that appointment. This allows us the reserve a large amount of time just for you. If you are unable to keep that reservation you are required to contact our office and let us know to avoid losing that deposit. The 2 business day rule applies here as well to avoid this charge.

____ ____________________________

Signature of Patient/Guardian Date