LAS POSITAS FAMILY DENTAL OFFICE POLICIES

Thank you for choosing our office to take care of your dental needs. Below are our Office Policies. Please review the information and sign/initial as indicated. If you have any questions, please let us know. Thank you!

- ❏ HIPAA Information and Consent Form (see attached)
  I, _____, date ___/___/_____ reviewed and understand the policies set forth by HIPAA. I do hereby consent and acknowledge my agreement to the terms set forth and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. (Initials)_____

- ❏ Cancellation and No-Show Policy
  We are a private dental practice, not a dental "clinic". Your health is extremely important to us. In order to provide the proper dental care that you need and want, we will need your help in maintaining your appointments. We reserve the time in advance to accommodate your busy schedule. We kindly ask that you extend the same consideration to us if you need to change or cancel your appointment. If you cannot make an appointment as scheduled, please notify the office as soon as you are able. **There will be a fee for rescheduled/cancelled appointments of $50 with less than a 48 hour notice.** We understand that illness and unforeseen emergencies occur and we will accommodate for these rare instances. *(Initials)*_____

- ❏ Financial Policy
  Payment is due when services are rendered. We accept cash, personal checks and major credit cards. We realize that some procedures are more extensive than others and we will be more than willing to work out alternative financial arrangements prior to treatment.

  *I understand and agree that, regardless of my insurance or marital status, I am ultimately responsible for the balance on this account for any professional services rendered. I understand my obligations and accept financial responsibility of services rendered at this office. (Initials)*_____

- ❏ Dental Materials Fact Sheet
  I reviewed the DENTAL MATERIALS FACT SHEET and understand that I will receive a copy of this form via email unless otherwise noted.
  ___Ok to receive by Email ___Received by Pamphlet (Initials)_____

Patient Information:
Name: _____
Date: ___/___/_____
Email: _____
Signature: _____

Witness Information:
Name: _____
Date: ___/___/_____