**Oakwood Family Dentists** P.L.L.C.

***Smile With Us***

Oakwood®

*Medical Staff Member*



# AGREEMENT TO PAY FOR TREATMENT

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential in information.

I, the responsible party listed below, hereby agree to pay all charges submitted by this office during the duration of treatment for the patient.

If the patient is insured with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable deductibles and co-payments which may arise during the course of treatment for the patient. **All co-pays are expected to be paid at the time of service.** Certain appointments may require payment be made in full or a portion of the estimated copay to reserve an appointment. The responsible party is also required to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers or if there is a balance that remains after the insurance company has remitted payment to us.

**Missed Appointment Policy**- If a patient fails to attend an appointment or cancel it at least two days prior will be considered a "broken" appointment and a $25 cancellation/no show fee will be applied to the account. This fee is not covered by insurance and is strictly the patient's responsibility. Patients who have two "broken" appointments may not be granted a scheduled appointment thereafter, but may still be considered for a walk-in appointment. We have created this two-day-notice policy to enable patients in need to be treated as soon as possible.

**Payment Options-** We accept Visa, MasterCard, American Express, Discover, Cash, & Care Credit as a means of payment.

**Collection Policy**- If circumstances force a patient's account to be forwarded to a collection agency for further handling or if patient declares bankruptcy, they will be expected to pre-pay any future appointments. Please note that patients whose accounts are not up to date must address the balance prior to being granted another appointment.

_____ _____

Patient/Guardian Name (Printed) Patient/Guardian Signature

_____

Date

# CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlined the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 – 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____ _____

Patient/Guardian Name (Printed) Patient/Guardian Signature

_____

Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Patient/Guardian Name)

_____ _____

(Signature) (Date)

**For office use only below:**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgment
- o An emergency situation prevented us from obtaining the acknowledgment
- o Other (Please specify)