Payment Policy

We will provide you with a treatment plan estimating your cost and any insurance benefits for dental care that you may need. Our practice requests payments at the conclusion of each visit. For patients with insurance, the **estimated** co-payment is requested at this time. As a courtesy, we will be pleased to submit insurance claims on our patient's behalf. Please note that any remaining balance, after insurance payment or denial, is the patient's responsibility to pay.

For treatment provided, our practice accepts cash, personal checks, and major credit cards, such as American Express, Visa, MasterCard, and Discover.

If you need to make financial arrangements for your portion, please feel free to do so with our Office Manager, in advance of dental treatment. We will be happy to discuss payment plan options and customize a payment plan for you.

We respect your time and we make a sincere effort to see all our patients on time. We ask that you respect our time and call us 48 hours in advance if you must cancel or reschedule your appointment. We waive the fee the first time you cancel without 48 hours notice, as we know emergencies do arise. **We charge a broken appointment fee of $50.00** the second time your appointment is cancelled with less than 48 hours notice. The third time this occurs, we regret to charge you **$75 per hour of allotted appointment time**. Please understand any changes in our schedule affects patients waiting to complete their dental care.

I have read and understand the practice's payment policy. Accounts not paid in a timely manner are subject to a late fee. I understand that if the terms of any payment agreement are broken, the account will immediately be turned over to a third party or collection agency.

____ ____________________

Signature of patient and/or guarantor Date

Patient Consent for Electronic Communication

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that we may send to you any of the following that you identify as communication that can be sent through the Internet to an email address you designate.

Consent and Acknowledgement

I ________________________________, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Email Address ____

Patient's Date of Birth (for verification purposes) _______________

I acknowledge that the practice may send the following to my email. Check each that apply, and then provide your initials at the end of each item selected.

☐ Information about my invoice or accounts payable _________

☐ Information about a specific dental visit _________

☐ Information about any dental visit _________

Acknowledgement

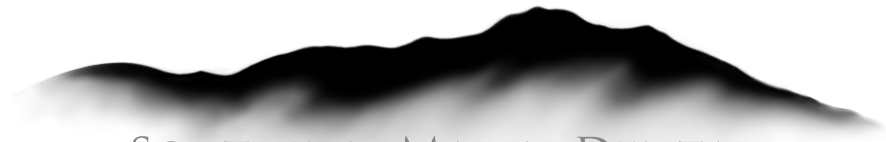
You must acknowledge each of the following before we can send communications electronically.

_______ I am responsible for providing the dental practice any updates to my email address

_______ I am able to receive information electronically and store it securely away from any public computer

_______ I can withdraw my consent to electronic communications by calling (415-383-2256)

Patient's Signature ____ Date ___________________



ACKNOWLEDGEMENT OF RECIEPT OF HIPAA PRIVACY POLICIES AND PROCEDURES

I, ________________________________, have received and reviewed a copy
(please print name)
of the health information privacy and security policies and procedures.

Print Name ____

Signature ______________________________________ Date ____________

ACKNOWLEDGEMENT OF RECEIPT OF THE DENTAL MATERIALS FACT SHEET

I, ________________________________, have received a copy of the Dental
(please print name)
Materials Fact Sheet as required by law.

Print Name ____

Signature ______________________________________ Date ____________