CENTER FOR DENTAL HEALTH, LA JOLLA

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

This information is necessary for our files and will be kept CONFIDENTIAL.

Center for Dental Health, La Jolla
8899 University Center Ln #190
San Diego, CA 92122
Ph. (858) 546-0100
Fax (858) 546-0495

Patient Name_____
Last First Initial

Social Security #_____

Phone_____

Email_____

I acknowledge that I have received a Notice of Privacy Practices from the above-mentioned office.

Signature of Patient (Parent if Minor)_____Date_____

FOR OFFICE USE ONLY:

I attest that to the best of my knowledge, the above information is correct.

Signature_____Date_____

Name_____Title_____

BROKEN APPOINTMENT OFFICE POLICY

Time has been reserved for you exclusively on our schedule. While unexpected situations may occur from time to time that may cause you to cancel your reserved appointment, please be informed that any appointment cancelled with less than 48 hour notification, or failure to show for your reserved appointment will result in a $50.00 charge for every 30 minutes of missed time.

Signature of Patient (Parent if Minor)_____Date_____

CENTER FOR DENTAL HEALTH, LA JOLLA

FINANCIAL POLICY

This information is necessary for our files and will be kept CONFIDENTIAL.

I have been informed and am aware of the following options in order to fulfill my financial obligation for dental services rendered.

1. Payment by cash or check at the time of service
2. Payment by VISA, Master Card, American Express or Discover at the time of service
3. Payment plan set up through CareCredit at least one week prior to scheduled services.

The total balance due is the legal obligation of the patient. The estimated amounts are only given as a convenience to the patient.

CONDITIONS OF TREATMENT

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by a insurance company.

A service charge of 1-1/2% per month (18% per annum, but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of 6 months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

It is our policy to charge $50.00 per 30 minutes for missed appointments without 48 hour notice. This fee must be paid prior to scheduling any future appointments.

I grant my permission to you, or assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above financial policy and conditions of treatment and agree to their content.

Signature of Patient (Parent if Minor)_____Date_____