

Consent for Services and Releases

initial - I understand that my appointment times are reserved. If I am unable to make a scheduled appointment, I agree to give 24-48 hours advance notice to reschedule or change appointments. I understand that this is a courtesy to others who would want my appointment time and must otherwise wait for other available times. I understand that those who abuse this courtesy may be subjected to No-Show or Late Cancellation fees, may be asked to place a deposit to hold future dental appointments, and/or may be unable to secure a timely return appointment as determined by needed length and type of service being rendered. [Note: The intent or spirit of this request is to ask that appointment agreements be honored, that other people's desire to access health care be respected, and that our dental office won't be abused due to careless disregard. We do understand about last minute emergencies and realize that most people are respectful and careful to manage their lives and plan sufficiently well enough to prevent undue 'emergencies.]

initial - I consent to: medical/dental history review, dental exam, X-rays, photos, and any treatment as indicated on my examination form, or treatment plan, including the use of local anesthetics, and oral sedation as necessary.

initial - I authorize Dr. Lee Ostler and/or dental staff to take photographs (pictures) relevant to the diagnosis of and explanation of dental conditions or problems. These images will be used as a record of my condition, care and treatment, to assist in diagnosis and treatment planning, and in communication with dental laboratories who may assist in my care.

initial - (Optional) I authorize Dr. Lee Ostler to use photographs of my face and smile for educational purposes in professional lectures and public educational presentations given by Dr. Ostler and/or his staff. I understand I will receive no financial compensation for this use.

initial - (Optional) I hereby give permission to have my testimonials and/or photos/videos used by Dr. Ostler and/or his staff for educational purposes to help other patients understand the benefits of modern dental services rendered. I understand I will receive no further financial compensation for this use.

Declaration of Financial Responsibility & Privacy Acknowledgment

initial - I understand that The Center for Dental Health is a private fee-for-service practice, is not a party to any health plan insurers, that all services will be charged directly to the patient/responsible party, and that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable at the time of services rendered, unless other financial arrangements have been agreed upon. As a condition of treatment in this office, financial arrangements must be made in advance to the delivery of services. Consent for and acceptance of services will constitute agreement to this understanding. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect collection of treatment fees and any balance due hereunder, whether or not formal collection activities are instituted.

initial - I understand that this office will help prepare the necessary insurance forms and will supply all supporting data required to file any insurance claims from any insurance carrier, and that it is the patient's responsibility to file insurance forms and interact with insurance companies. I understand that this office will not render services on the assumption that charges will be paid by any insurance company.

Initial - I grant permission to you or your assignee, to contact me at home or at my work, to discuss matters related to this form, my financial responsibilities, and matters of treatment.

Initial - As per the "Privacy Acknowledgment" I authorize the release of all necessary information to any insurance carrier(s) or their representatives, from whom I seek reimbursement.

Initial - I have read the above agreements and conditions of treatment before signing below, and agree to their content. I have received a copy of this agreement (or if filled out online, have printed a copy for my records).

X

Signature of patient, parent or guardian (online-type name on form)

Date

Relationship to Patient