Office Policies

This office takes your scheduled appointment very seriously. There are very few dental providers that accept Medicaid Insurance programs. As such, many of our patients travel long distances and wait more than a month for their treatment. Missed appointments and late cancellations force a delay in treatment for other patients who are often in considerable discomfort. Therefore, we have instituted the following policies:

- Patients scheduled for General Anesthesia/Sedation must confirm their appointment 48 hours prior to their scheduled surgery. If we do not hear from you, the scheduled appointment will be cancelled.
- Our office strives to stay on schedule. If you are more than 10 minutes late for your scheduled appointment, you may be asked to reschedule.
- Insurance cards(if applicable) must be brought to each appointment
- Minors (children under 18 years of age) must be accompanied by a parent or legal guardian.
- Unfortunately, at this time we do not provide translators. Si no comprende Ingles, viene conun traductor adulto.

Our office will do our very best to inform you if the recommended service is a non-covered benefit, however, understanding coverage and limitations remains the responsibility of the insured. Payment for non-covered services is expected at the time services are rendered.

I have read and agreed to the above office policies.

_____ _____

Patient or Legal Guardian Signature *Today's Date*

Authorizations to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. You have the right to refuse to sign this acknowledgement.

I, _____, have received a copy of the this office's Notice of Privacy Practices.

_____

Patient Name (Printed)

_____

Patient or Legal Guardian Signature

_____

Date