Pacific Dental Center Office Policies

Financial Policy:

Treatment cost estimates are provided to you, the patient, and prior to treatment. We will file insurance claims on your behalf; however your shares of costs are due at the time of service. Although we file insurance claims for you, ultimately the responsibility rests with the patient or responsible party. If after 60 days, no payment is received from your insurance carrier, payment in full will be due from the patient at that time.

All accounts over 90 days will be subject to an 18% per annual finance charge. Any accounts sent to a collection service will be surcharged an additional fee.

Initials: _____

Local Anesthetics

The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate but will return to normal. Common complications that can occur from local anesthetic but are not limited to: are pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to: permanent numbness, abnormal sensation, transient blindness.

Initials: _____

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures due to condition found while working on the teeth that were not discovered during an examination. I give permission to Dr. Snow to make any/all changes and additions as necessary once I have been informed of these changes and consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increased complexity of the treatment outcome, or eventual loss of teeth.

Initials: _____

Cancellation Policy:

All appointments require 2 business days' notice of cancellation. A minimum of $75 will be assessed if a cancellation occurs in less.

Initials: _____

Please Flip Over

Authorization for Signature on File:

I hereby authorize the office of Pacific Dental Center to affix my name to any and all claims and documents as related to any and all benefits due me and my dependents through my employment with my employer. I further authorize payment of dental benefits otherwise payable to me, directly to Pacific Dental Center. **A photocopy of this document acts as the original.**

Initials: _____

_____ **Date:** _____

Patient Signature

_____

Office Witness