

PARTNERS IN DENTAL HEALTH LLC

Our team at Partners in Dental Health is committed to providing the best dental care for your particular needs. We are part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. In addition, we are also dedicated to making top-quality care as cost effective as possible. To assist with your health care investment, we provide the following payment options: Cash or Check, Major Credit Cards (MasterCard and Visa), or Care Credit.

Payment is due at the time of treatment. To enable you to proceed without delay, our office offers several financial options. We encourage you to select a financial arrangement that best suits your budget.

A Returned Check Fee of \$25.00 will be charged for any check returned for insufficient funds ____ (INT)

All account balances over 60 will be assessed a handling charge of 1.5% per month (18%APR). All accounts over 90 days will be transferred to a collections agency. At that time, all costs of collection, including attorney and legal fees, will be added to your account balance.

Insurance Policy

Our goal is to maximize your insurance benefits and make any remaining balance easily affordable. Please be prepared to show your insurance card and driver's license at the time of your visit. If the patient has any insurance changes, it is the patient's/guarantor's responsibility to provide the new information. If this information is not provided at the time of service, the patient/guarantor will be responsible for all charges incurred. ____ (INT)

I understand my dental insurance is a contract between the insurance carrier and myself; not between Partners in Dental Health LLC and the insurance carrier. As a courtesy, Partners in Dental Health LLC will gladly submit your insurance to your primary and/or secondary insurance. The patient/guarantor is responsible for their estimated portion and additional fees at the time of service. Please be aware that some insurance companies may not cover all services performed in our offices. If for some unforeseen reason your insurance payment is not paid within 60 days, the patient/guarantor is responsible for the charges that are denied or unpaid by insurance. Most insurance companies will not pay for composites (white fillings) on posterior teeth. Instead, they pay their allowance for an amalgam (silver filling). You are responsible for the difference. Please keep this in mind as here at Partners in Dental Health LLC, we do not do amalgam fillings. ____ (INT)

Authority of Treatment

I hereby grant authority to Dean E. Kent DDS PC; Keenan M. Davis DDS PC; John W. Kent, DDS, and/or Mathew E. Kent DDS PC to the dentist(s) in charge of my care, to administer any treatment, to administer such anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case.

In the event the doctor of a team member is punctured by a sharp instrument, I agree to have my blood tested. I acknowledge that I have been informed of the risk and possible consequences of the treatment proposed and do authorize the above name doctor(s) to proceed. ____ (INT)

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with minimum of 2 business days notice. Our office does not accept cancellation or changes in appointment after hours by voicemail: you must call during business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. ____ (INT)

Office Hours

Monday, Friday: 8AM to 5PM

Tuesday, Wednesday, Thursday: 8AM to 6PM

Missed Appointment Fee:

Missed appointment fee of \$69.00 will be charged to any patient who does not notify our office within two business days to cancel or reschedule their appointment. ____ (INT)

HIPPA Privacy Practices

We practice standard HIPPA policies and provide a pamphlet to you of our office policies to protect the patient and sensitive information.

I have read and agree to the policies and received notice of Privacy Practices

Patient's Name (print)

Patient or Parent Signature

Date