Blairmore DENTAL CENTRE

Informed Consent

APPOINTMENTS

1. We require a minimum of 24 hours' notice to cancel OR change any appointment. A $75.00 fee will be charged if an appointment is missed or cancelled without sufficient notice.
2. We offer a reminder call the day before your appointment. Please note that this is a **courtesy** call. If you do not receive our call and/or message, you are responsible for missing the appointment that you scheduled.
3. If patient is under 18 years of age, a parent/legal guardian **must** be present for duration of the appointment.

PAYMENT OF FEES

4. As a service to you our office will accept direct payment from your insurance company. You are responsible for providing the necessary information for us to direct bill your insurance company as well as informing us of any changes in this information.
5. Our office provides electronic/manual billing to your insurance company on your behalf. Please note however, that due to the privacy act, **YOU ARE RESPONSIBLE TO KNOW AND MONITOR YOUR OWN PLAN'S COVERAGE AND MAXIMUMS.**
6. If your dental plan does not cover the full cost of your treatment. **YOU WILL BE RESPONSIBLE FOR ANY DIFFERENCE** between the amount paid by your plan and the amount charged.
7. Your portion is then due and payable **ON THE DAY OF YOUR APPOINTMENT**.

WE ACCEPT DEBIT, VISA & MASTERCARD. **WE DO NOT ACCEPT CASH.**

GENERAL RELEASE

I, the undersigned, certify that I have provided accurate and complete registration information and have not knowingly omitted anything.

CONSENT

I, the undersigned, hereby authorize the dentist or his auxiliaries to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs. I authorize the dentist to perform and apply any and all forms of treatment, medication, and therapy that may be indicated, and consent to the use of local anesthetic agents. I understand the above statements regarding the payment of fees and **accept the responsibility for payment** for dental services provided for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

I consent to collection, use, retention, and disclosure of personal information as is required for my own and dependents dental care.

Patient's Signature:..... Date:.....

Parent or Responsible Party's Signature:.....

Relationship to Patient:.....