ELISON DENTAL

ACKNOWLEDGEMENT & CONSENT

Acknowledgement of Financial Responsibility: I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. This is including deductibles, co-pays, and any estimated portion insurance is not covering. I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Elison Dental Center. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Elison Dental Center. In the event payments are not received by agreed upon dates, I understand that a **$25 charge** per late payment may be added to my account. I also authorize Elison Dental Center or insurance company to release any information required to process my claims. I further agree to inform Elison Dental Center of any address or phone number change within **30 days** of such a change. In the event I fail to do so I authorize Elison Dental Center to use all due means, including the use of credit history records, to ascertain my new address for billing purposes. If accounts are not taken care of, the collection process will begin with notifications up to **90 days** it will be sent to **Bonneville collections**. You can also set up a payment plan for treatment plans above **$500**, a card will be needed and it will be kept on file for automatic payments.

Notice of Privacy Practices: I acknowledge that I have received the Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Consent for treatment: I hear by authorize the doctor or designated staff to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs. Upon diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to use of anesthetics, sedatives, and any other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

Office policies: The office is open Monday-Thursday from 8:00am-5:00 pm, and every other Friday 8-12:00 pm. We require a **24-hour notice** if you need to cancel/reschedule an appointment. Anyone late **15 minutes** for an appointment will not be seen that day and we reserve the right to charge a fee. Missed appointments without prior notification are also subject to a fee of **$25-$50**. We guarantee all dental work for **2 years** completed in our office and crowns for **5 years** if not tempered with in another office. The only requirement is that you visit every six months for checkup and cleaning.

Final Signature: The above information is true to the best of my knowledge. I understand and will comply to the terms listed.

Patient Signature Date

Parent/Responsible Party Signature Date