

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 2% per month (24%A.P.R.) of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I understand that any rescheduling of my appointments must be made at least 24 hours prior to the appointment date and that if I fail to cancel any appointment at least 24 hours prior to appointed time I will be charged a missed appointment fee of \$30.00 per scheduled hour.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian

Date

Relationship to Patient _____

CONSENT TO PROCEED

I authorize Dr. Clinton Miller and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____
(Patient, legal guardian or authorized agent of patient)

Date: _____

Witness: _____

Date: _____

PATIENT INFORMATION SHEET

Date: _____ Referred
By: _____

Patient's Name: _____ SSN: _____ Birthdate: _____ Age: _____

Address: _____ C/S/Z: _____

Phone #: _____ Sex: M F Marital Status: M S W D No. of Dependents: _____

Employer: _____ Phone: _____ Occupation: _____

Student? F/T P/T Name of School: _____

Spouse: _____ SSN: _____ Occupation : _____

Employer: _____ Phone: _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ Phone: _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person: _____ Relationship: _____

Residence Address: _____ C/S/Z: _____

Hm. Phone #: _____ SSN: _____

Employer: _____ # of Years Employed: _____

Employer's Address: _____ C/S/Z: _____

Union Local No.: _____ Wk. Phone #: _____ Dental Insurance: _____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name: _____ SSN: _____

Patient's Relationship to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Employer: _____ Phone #: _____ Union Local: _____

Insurance Company: _____ Group # : _____

Claims address: _____

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name: _____ SSN: _____

Patient's Relationship to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Employer: _____ Phone #: _____ Union Local: _____

Insurance Company: _____ Group # : _____

Claims address: _____