Szabo Family Dentistry Office Policies

IMPORTANT- Please read each section thoroughly. Sign or Initial each section in the space provided indicating that you have read and understood that section.

Treatment Consent *(if patient is a minor)*

The permission of a parent or legal guardian is necessary for dental treatment of a minor. As a minor child, it is necessary that signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of _____ I acknowledge that the information provided is correct and grant Szabo Family Dentistry permission to provide my child's dental treatment as deemed necessary, including x-rays, diagnostic, and restorative that are reasonable, necessary and advisable.

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, metals and any other diseases or condition, including pregnancy.

I agree to inform Szabo Family Dentistry of any changes in the medical history. This authorization is valid until revoked by me in writing.

Signature:_____ Relationship to child_____ Date_____

Financial Policy

Our Financial Policy has been established to ensure that the best services can be provided to you and your family and any misunderstanding can be avoided. Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. With or without insurance coverage, you are responsible for full payment of you total bill. Payment is due and payable at the time of service and all co-payments and deductibles are also due at that time. You are expected to pay the estimated portion of your fee at the time services are rendered. **However, this is only an estimate** – if there is any difference after your insurance pays, we will send you a statement.

We offer a 5% courtesy for your payment in full with cash or a check. For your convenience we accept Care Credit, VISA, Master Card, Discover and debit cards.

I understand the financial policies above and agree to comply with them. I agree that parents are responsible for all fees and services rendered for treatment of their dependent children.

Patient or Responsible Party Signature _____Date_____

initial

Late Arrivals Late arrival for a scheduled appointments leads to inadequate time to accommodate the remaining patients on the schedule. Late arrivals of greater of 10 minutes risk not being seen. We will try to accommodate late appointments as time permits.

initial

Failed appointments We expect patients to be present at all scheduled appointments exclusively reserved for them. 48-hour notice is required. After 3 failed appointments (missed appointments without 48-hour notification) you will be dismissed from our practice.

initial

Appointment reminders We may use or disclose your Dental information to provide you with appointment reminders, such as voicemail messages, e-mails, postcards or letters.