General Treatment Consent & Office Policies

1.) Direct Authorization for general treatment (Preventative, Restorative, Prophylaxis and X-rays by Unique Smile Dental Associates. I authorize Ashland Elite Dental for myself /parent/guardian on behalf of the Minor Patient.____ Initial

2.) **FINANCIAL AGREEMENT**
Payment is due at the time of service. As a courtesy to you, we will submit all charges to your insurance company. Insurance is designed to cover a portion of our fees only; Your Co-pay will be collected at each appointment. I authorize my Insurance Company to make direct payment to Ashland Elite Dental Associates._____ Initial

3.) **CANCELLATION AND FAILURE TO KEEP APPOINTMENT**
We understand that circumstances do arise that can keep you from your scheduled appointment. We require a 72 hour notice to change/cancel any appointment, as a result of this policy the following charges may apply. General/Hygiene $60.00. Specialist (5 days notice)$110.00_____Initial

4.) **X-Rays**
Original x-rays are the property of Ashland Elite Dental. If you request to have your x-rays duplicated, there will be a $28.00 charge. Please allow 72 hours for duplication processing, prior to pick up or mailing. _____Initial

5.) **APPOINTMENT REMINDER CARDS/COURTESY CONFIRMATION CALLS/TEXTING/ EMAIL**
I give Ashland Elite Dental permission to send a reminder post card by U.S. post office, via internet, telecommunication. _____Initial

6.) **COLLECTIONS**
Failure to pay your balance within 90 days; your account will be sent to a collection agency. There will be a $50.00 charge to process the collections account. _____Initial

By signing below, I understand and agree to the above listed General Consent for Treatment and Office Policies, for treatment and services rendered.

Patient/Parent/Guardian_____Date_____

ASHLAND ELITE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

_____
{Person Authorized to Release Information to (ex. Spouse, Parent, Guardian, or Sibling)}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).