DESERT CACTUS
DENTISTRY

Patient Responsibility

Please Initial Below

Authorization for Treatment

____ I authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

____ I consent to the use of appropriate medication as deemed necessary. I fully understand that using anesthetic agents and nitrous causes a certain risk.

Late Arrival

____ I understand that if I arrive 10 or more minutes late to an appointment the doctor will need to determine if there is enough time to complete any or all treatment or if it is necessary to reschedule.

No Show

____ I understand that I will be considered a no show if I do not call **24 hours in advance** to change or cancel an appointment reserved for me or dependents. After one no show, I will be required to pay a DEPOSIT of $50 per appointment to reserve any future appointment times. The deposit is forfeited only if I cancel, arrive over 10 minutes late or miss my appointment.

(If Applicable) Consent for Treatment of a Minor

____ I declare that I am the parent or authorized guardian of the patient, who is a minor.

Notice of Information Practices

____ I have read and fully understand Desert Cactus Dentistry's Notice of information Practices.

Authorization to Release Information Purpose: This section is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.
I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
(Please Print Name) Relationship

_____
(Please Print Name) Relationship

_____
(Please Print Name) Relationship

Financial Policy

____ I understand that ALL responsibility for dental services provided in this office for myself or my dependents is mine. Payment is due and payable PRIOR to work being completed. If insurance is used, the co-pay is due PRIOR to work being completed.

____ If my account goes unpaid 90 days past the date of service, I agree that I am responsible for paying the balance of treatment, additional collection fees and reasonable attorney fees incurred in collecting the balance.

Insurance

____ I would like Desert Cactus Dentistry to assist me with my dental insurance plan and submit claims on my behalf. I understand Desert Cactus Dentistry can only give me an ESTIMATE (not a guarantee) of what my insurance will cover and that I am responsible for the total amount of all work completed. I understand that I can also call my insurance company and get estimated payment information at any time.

____ Sixty (60) days for the date of service, if for whatever reason, the insurance company has not paid Desert Cactus Dentistry, I agree to immediately pay the BALANCE due. If the balance goes over 90 days, the account will fail under collections.

____ I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my name and signature or any other required information on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

Photo and Video Consent

____ I give Desert Cactus Dentistry consent to use my photo or video for internal and external marketing.

Payment Options

We want our patients to be able to afford dental care. We will gladly discuss our payment options with you before beginning your treatment. We offer the following options:

- **Cash**
- **Debit and Credit Card**
- **Patient Financing**

I understand the information on this form and that it is my responsibility to advise your office of any changes in the information.

Patient_____ Date_____

Parent of Responsible Party _____Relationship to Patient_____

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