Toole Family Dentistry Financial Policy Statement

Payment for services, including deductibles and copayments, are due at the time of the service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment.

Toole Family Dentistry accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The dental benefit contract is an agreement between you and the dental benefit company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that your dental plan is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

Checks that are returned to our office from your financial institution are subject to a $25 returned check fee. This fee covers the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation. Please indicate your understanding and acceptance of these financial policies by signing below.

Dental appointments for treatment other than routine cleanings require a non-refundible deposit of $50 per hour of treatment scheduled. The deposit is applied toward your dental treatment.

Patient's name ____ Date________

Patient, guardian or guarantor signature______________________________ Date________

Witness____ Date________

Toole Family Dentistry Cancellation Policy

We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances. However, we require patients to reschedule or cancel appointments within 48 hours of a scheduled visit.

If you 'no show' or fail to reschedule/cancel an appointment without giving 48 hours notice a $50 charge will be applied for every missed appointment. You cannot be rescheduled until the fee is paid. If there are more than three missed appointments on file then we may ask that you call the day you are available to be worked into the schedule.

Missing an appointment prevents us from providing care to you and is detrimental to our business because it prevents us from scheduling another patient who needs care.

Print Name: ______________________________

Sign: ___________________________________

Date: ___________________________________

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

____

Patient Name (Please Print)

________________________________ ________________________________

Patient Signature Date

OR

____

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: ____________________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Toole Family Dentistry General Consent To Dental Procedures

Patient: ______________________________

Date of Birth: ______________________________

REGARDING MY MEDICAL HISTORY:

______ (initials) I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify Dr. Kevin Toole of any changes at any subsequent appointment.

REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:

______ (initials) I do hereby authorize and request the performance of dental services by Dr. Toole and such associates or employees he may designate, and the use of whatever procedures Dr. Toole may deem necessary or advisable to maintain my dental health, or the dental health of any minor or other individual for which I am responsible for treatment. Any restorative treatment or therapy such as crowns, fillings and extractions will require my additional consent to treatment.

REGARDING ANESTHESIA:

_______(initials) I authorize for myself, and any minor or other individual for which I responsibility, the administration of any anesthetics, analgesics or sedative, including without limitation, nitrous oxide, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by Dr. Toole. I understand that anesthetics may be therapeutic, diagnostic, or for treatment of facial pain. I understand that antibiotics, anesthetics, analgesics and other medications may cause complications and reactions including without limitation, allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that additional complications may include, but are not limited to pain, swelling, bruising, temporary limited opening, hematoma, cardiac stimulations, muscle soreness, temporary or permanent numbness, and local infections. I understand that in occasional cases, the anesthesia may be prolonged and in very rare cases permanent.

REGARDING DENTAL TREATMENT:

_______(initials) I understand that any treatment plans presented, along with any fees outlined, could change depending on the time elapsed since the initial examination and the extent of dental pathology. I understand that once the treatment plan has begun, complications may arise that dictate additional procedures or treatment. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize Dr. Toole to make any/all changes and additions as necessary.

_______(initials) I understand that a more extensive restoration than originally planned, including but not limited to root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

_______(initials) I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I will receive.

CONSENT: *I have had the opportunity to have all my questions answered by Dr. Toole, and certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is propose to me, together with the known risks and complications associated with that treatment. I hereby give my consent.*

____

Patient/Guardian Signature and Date

______________________________ ______________________________

Print Guardian Name **Relationship to Patient**