OAKWELL DENTAL CARE 3301 Oakwell Ct., Suite 102 San Antonio, Texas 78218 (210)832-9993

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 performed.

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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Patient / Parent or Guardian of Patient Signature **Date**

Acknowledgement of Receipt of Notice of Privacy
"HIPAA"

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

_____ _____

Patient / Parent or Guardian of Patient Signature **Date**

Notice of Office No Show Policy

Due to the burden everyone shares when there is an open time in our schedule, it is necessary to enforce our **No Show Policy.**

All patients are required to give 48 hours notice to cancel or reschedule appointments. If a patient does not give 48 hours notice to cancel or reschedule his / her appointment, a $25.00 fee will be applied to the account. This is the patient's responsibility and will not be billed to any insurance company. The fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not.

By signing below I hereby acknowledge and understand the office policy listed above.

_____ _____

Patient / Parent or Guardian of Patient Signature **Date**