CONSENT FORMS

Patient Name: _____ **DOB:** _____

INSURANCE BENEFITS:

Each insurance company offers several different insurance plans to their clients. Each of these insurance packages offer widely varying benefits, depending on the cost that the employer has available for that purpose. The "UCR" benefits you receive are based on a fee structure chosen by the insurance company for the package that your employer has selected. These fee schedules are not always a true reflection of what is a "usual and customary rate" in terms of our demographic area or the quality of dentistry we provide. Because of numerous plans and different fee schedules, we can only estimate your expected coverage. Keep in mind that insurance estimates are estimates only. Treatment fees are estimates and could be altered if your dental needs change. It will be our pleasure to assist you in maximizing your insurance benefits. Please advise us of any dental benefits used elsewhere. We will make every effort to discover the approximate amount your insurance will cover per procedure and bill your insurance company as a courtesy to you. Ultimately, however, you are responsible for all payment of treatment provided, regardless of any insurance involvement.

H.I.P.A.A. PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the rights to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such reactions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I acknowledge that I received from Arden Park Dental Care a copy of the Dental Materials Fact Sheet dated May 2004.

CANCELLATION/NO SHOW POLICY

Arden Park Dental Care requires a 48 business hour notice to cancel any appointments. The first cancellation made within the 48 business hour period will incur a charge of $50 and the second cancellation will incur a charge of $75 for basic services such as cleanings. If your appointment exceeds more than 60 minutes the cancellation/failed appointment fee will be $200 or higher depending on the amount of procedure time you are scheduled for.

_____

Patient Signature Date