JAFFE DENTAL GROUP

ELECTRONIC CONSENT

- I consent to the use of email for communications from the office. I also agree to the office communicating electronically with specialists and other medical offices that I may be referred.
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling or writing the office.

Email Address:_____

Patient Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I have received and reviewed a copy of this office's Notice of Privacy Practices. I understand my rights under this policy.

Patient/Guardian Name (Print):_____

Patient/Guardian Signature:_____ Date:_____

For office use only below:

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, stud models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use of disclosure or any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient/Guardian Name (Print):_____

Patient/Guardian Signature:_____ Date:_____

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party listed below, hereby agree to pay all charges submitted by this office during the duration of treatment for patient.

If the patient is insured with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable deductibles and co-payment which may arise during the course of treatment. **All copays are expected to be paid at the time of service.** Certain appointments may require payment be made in full or a portion of the estimated co-pay in advance to reserve an appointment. The responsible party is also required to pay for treatment rendered which is no considered to be a covered service by third party insurers or if there is a balance that remains after the insurance company has remitted payment to us.

If a patient fails to attend a scheduled appointment or cancels with less than two (2) business day notice, it will be considered a "broken appointment" and a fee of up to $120 may be applied to the account. This fee is not covered by insurance and is strictly the patient's responsibility. Patients who have two or more broken appointments may not be granted a schedule appointment thereafter, but may still be considered for walk-in appointments. This policy has been created to enable patients in need to be treated as soon as possible

Payment Options include Visa, Mastercard, American Express, Discover, Cash, Check, and CareCredit.

If circumstances force a patients account to be forwarded to a collection agency or attorney for further handing or if a patient declares bankruptcy, they will be expected to pre-pay for any future appointments. Please note that patients whose accounts are not up to date must address the balance prior to being granted another appointment.

Patient/Guardian Name (Print):_____

Patient/Guardian Signature:_____ Date:_____