APPOINTMENTS

Because we recognize the value of your time, you can expect us to see you at the appointed times, so as to keep your time spent in our office as short as possible. Likewise, when you make an appointment with us, we have reserved our times just for you and ask that you be on time. If you cannot keep your appointment, we ask you to give us **at least 48 hours notice** so that we can give your time slot to another patient. Otherwise, our office policy is to charge an hourly rate to help defer some of the overhead expense associated with not having a patient scheduled in your time slot. We believe very strongly that mutual trust and respect for each other's time will strengthen our relationship.

FINANCIAL POLICY

- Unless another financial option is pre-arranged, payment in full is due the day of treatment.
- For procedures requiring long appointment times, 1/3 of the payment is expected to reserve the appointment time.

PAYMENT OPTIONS

1. For your convenience we accept Cash, Check, Visa, MC, Discover and AE.
2. A 5% discount is offered for any treatment plan paid in full at the time the appointment is made.
3. We also offer short and long-term financing through Care Credit and Lending Club.

FOR PATIENT WITH DENTAL INSURANCE

- As a courtesy, we will accept assignment of your insurance benefits provided we are able to verify current coverage and have received a copy of your insurance card or a signed, completed dental insurance form.
- We will estimate your insurance benefits and will expect your portion of the fee to be paid at each visit. You are responsible for any portion your insurance company does not cover. If for any reason your insurance company pays less than what was estimated, you will be responsible for the unpaid balance.
- If the balance is not paid within 30 days of the billing date, a finance charge of 1.5% per month will be added to the account. In case of default of payment, you will be responsible for any interest on the balance due, together with any collection costs and reasonable attorney's fees incurred in the collection of this account.

AUTHORIZATION AND CONSENT

GENERAL CONSENT TO TREATMENT

I agree and consent to a dental examination by Dr. Foto. I understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

RELEASE OF INFORMATION

I authorize Dr. Foto to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize and request my insurance company to pay my benefits directly to Dr. Foto.

PHOTOGRAPHY RELEASE

I authorize Dr. Foto to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

My signature acknowledges that:

I understand the office policy with keeping Appointments.
I understand and will comply with the office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
I assign my insurance benefits to Dr. Foto.
Photographs taken of me may be shown to other patients.
I have received a copy of this office's Notice of Privacy Practices.

X_____ Date_____

Signature of Patient, Parent or Guardian