Dennison Dental Care
Ekaterina Yankelevich, D.D.S.

CONSENT FOR TREATMENT

The undersigned hereby authorizes Dr. Yankelevich, or a clinical staff member to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Yankelevich to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Yankelevich to perform any and all forms of treatment and therapy, and prescribe or apply medication that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Dr. Yankelevich choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Signature_____ Date_____

OFFICE AND FINANCIAL POLICIES

1. **Cancellations require a 24 hour notice.** In the event you cannot make your scheduled appointment, [at least] a 24 hour notice is required. Failure to give such notice or arriving too late for a scheduled appointment time will be considered a broken appointment, and will need to be rescheduled. The fee for a broken appointment is **$25.00 per patient, per scheduled hygiene appointment**, and **$50.00 per patient, per scheduled appointment with Dr. Katya**. Habitually failing to keep appointments is grounds for dismissal from our practice.

2. If you have insurance, we will bill your insurance company for you. However, **any co-pays or procedures not covered by insurance are to be paid the same day services are rendered**. In order to provide this service for you, we must have complete insurance information. **For patients not covered by insurance, payment is expected the same day services are rendered.**

3. Due to the nature of our automated billing system, **if your insurance company has not made payment within 45 days of billing, the balance becomes your responsibility**. Please remember that insurance is an agreement between the insured and the insurer. Therefore, if any problem arises with the carrier, we will ask that you handle it with your insurance company. Our office will provide your insurance company with any additional information that is necessary for resolution.

4. **It is your responsibility to be familiar with your insurance benefits and its limitations.**

5. All accounts not paid within 30 days of statement date may be subject to late and/or finance charges.

6. Regarding our child patients, the parent who brings them in is the responsible person for payment. Children under age 18 who are here for dental work must be accompanied by an adult.

7. All major dental work done in this office has a one year guarantee provided that you come in for your regular check-ups and cleanings.

8. All [related] account balance must be paid in full to receive or transfer a copy of records.

Please sign and date to let us know you have read and understand our policies.

Signature_____ Date_____