

COLUMBIA CENTER FOR DENTISTRY

Thank you for choosing Columbia Center For Dentistry. Our goal is to provide exceptional dental services and products in a comfortable, caring manner. We believe you expect us to understand and honor your individual needs and goals. So that we may serve you best, please read the following office policies and sign in the spaces provided.

APPOINTMENT RESERVATIONS

We schedule by appointment only. When you request an appointment we reserve that time exclusively for you and do not offer it to anyone else. If, for any reason, you are unable to honor your reservation we require at least 48 hours notice. We reserve the right to require a deposit to hold a reservation and charge for failed or cancelled appointments.

Sign: _____ **Date:** _____

PAYMENT FOR SERVICES

Payment is due when services are rendered. We accept cash, checks, debit cards, Visa, MasterCard, and Discover. We offer financing through CareCredit for those who qualify. Arrangements must be made before your appointment. Returned checks will be charged \$25 and sent to the prosecuting attorney. Delinquent accounts will be pursued by a collection attorney and charged legal fees.

Sign: _____ **Date:** _____

DENTAL INSURANCE

Dental insurance benefits rarely cover 100% of your services. Any amount not covered by or excluded from your plan is your responsibility and payable immediately. We do not guarantee insurance benefit estimates or coverage. We will file your primary claims and accept assignment of benefits as a courtesy. Disputes regarding reimbursement are between the policyholder and the insurance plan provider.

Sign: _____ **Date:** _____

RELEASE OF INFORMATION

By signing below, you authorize the release of information from Columbia Center For Dentistry to insurance companies or other health care providers, whether manual or electronic, for any purpose deemed necessary. You further consent to using your photographs, radiographs, and technical information for unlimited use by Columbia Center For Dentistry.

Sign: _____ **Date:** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have received a copy of Columbia Center For Dentistry's Notice of Privacy Practices (HIPAA regulations) and agree to its terms.

Sign: _____ **Date:** _____

INFORMED CONSENT FOR TREATMENT

I consent to treatment by C. Bradley Miller, DDS, and/or his designees. I understand that dentistry is not an exact science and that unpredictable complications can occur and results cannot be fully guaranteed. By allowing treatment, I have accepted these terms. Dental restorations wear out over time and need maintenance, replacement, or further treatment. I understand the importance of consistent, thorough home care and periodic professional treatment.

Sign: _____ **Date:** _____