LAKE AREA DENTISTRY

Welcome to our office! We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to providing the highest quality dental care and services to our patients. We take great pride in each staff member's training and capabilities. Please tak a few minutes to read the following information. By siging this form below you are stating you understand and consent to treatment for yourself or a family member.

Consent:
Treatment of the human body, including dental treatment has some inherent risks and limitations. These are seldom serious enough to contraindicate the recommended dental treatment, but should be considered in making the decisions to proceed with treatment. Please ask any questions that come to mind concnerning treatment, risks and limitations. There is no guarantee of success, but of course this is our goal.

Referral Information:
Who can we thank for referring you to our practice? _____

Financial Policy:
Payment is expected at the time of treatment. Some special procedures may require that payment be made prior to treatment. Our office accepts all major credit cards. Care Credit is also available to our patients, with approval, as a convenient payment alternative. There is no application fee and monthly payments can be tailored to fit your budget with Care Credit.
We are happy to accept your Personal Check, it must be written on an active account with a local bank. There is a $25.00 charge for any check returned by your bank. Our auditors allow ten (10) days for correction.
A finance charge of 1.5% per month (annual rate of 18%) will be added to all past due accounts (over 30 days). In the event a collection agency should become necessary to collect an unpaid balance, a $25.00 collection fee will be added to your account.

Appointments:
To ensure we deliver exceptional dental care, we want to share with you that we are 100% committed to providing timely and quality service to all of our patients. However, we also believe that an important aspect of delivering exceptional dental care is our patients' commitment to our practice as well. We consider an appointment made to be an agreement between our office and you. Therefore, we request that you honor your reserved appointment as scheduled. Should you have to change your appointment for any reason, a 24 HOUR ADVANCE NOTICE IS REQUIRED. A LATE CANCELLATION CHARGE OF $50.00 will be applied to your account for cancelling an appointment with less than 24 hour notice. We appreciate your understanding in this matter.

Please do not hesitate to ask if you have any questions regarding this agreement. We are committed to providing you with an ultimate experience in dental care.

I have read and understand this agreement and herby authorize dental treatment for the person named below and agree to pay all charges for such treatment.

_____	_____	_____
Print Name of Patient	Signature of Patient or Responsible Party	Date

LAKE AREA DENTISTRY

I understand that, under the Health Insurance Portability & Accountability Act of 1990 "Hippa", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payors.
3. Conduct normal healthcare operations such as quality assessments and physicians certification.

I have been informed by you of your Notice of Privacy Practices which contains a more complete description of the use 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 Lake Area Dentistry, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Lake Area Dentistry, LLC at any time to obtain a current copy of the 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 that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

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 content.

Print Name of Patient	Signature of Patient or Responsible Party	Date