Alpha Dental Center, P.C.
230 Rhode Island Ave
Fall River, MA 02724

I. Informed Dental Consent

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedure we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures and all of the questions have been answered. Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to ones body, including dental treatment, there are no guarantees that the results will be as planned and to each individuals' satisfaction. When dealing with the human body there are many variables involved, some predictable and others not. Complications in dentistry are very low but they do exist. Even minor procedures like a simple "fillings" can lead to major complications that cannot be foreseen. For example, a "Novocaine" injection or local anesthetic injection can lead to an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and/or hospitalization or death. Granted these are daily uncommon occurrences but individuals who are contemplating treatment should be aware of this prior to consenting. Whenever drilling is involved even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment plan to bring and to temperature extremes (hot & cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read and understand Informed Dental Consent and consent to dental treatments. INITIALS_____DATE_____

II. Financial Policy

Patients WITH insurance coverage:

Please understand that your insurance policy is a contract between you and your insurance company. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carries if you request to do so. Routine treatments are generally performed with out submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment, if your insurance company has not paid for the alternative benefits other than the treatment performed such as (white fillings). In this case, you are responsible to pay for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility. All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion. If you are having extensive treatment over a period of time, we request payment during the course of the treatment. Our financial coordinator will assist in arranging a payment schedule.

Patients WITHOUT insurance coverage:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, MasterCard, Visa, Discover, American Express, and ATM/Debit Cards. We also arrange financing options with a 0% interest rate with CARECREDIT if over the needed amount.

III. Office Policy Concerning Scheduling Appointments

When you make an appointment, we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We reserve the right to charge for any appointment(s) broken without a 24 hour notice. The charge will be $25.00 for every (45) minutes of appointment time.

INITIALS_____DATE_____

IV. Billing Policy

Checks returned unpaid from the bank are subject to $25.00 service fee. If your account is sent to our collection agency you will be responsible for collection and court cost along with attorney's fees.

I have read and understand Alpha Dental Center's informed dental consent, financial policy, scheduling and billing policy.

PATIENT/GUARDIAN NAME: (PLEASE PRINT) _____DATE_____

SIGNATURE: _____