WELCOME TO AVASON FAMILY DENTISTRY

Taking care of you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our dental fees and your payment options. At the onset of treatment, we will provide you with an *estimate* of the total fees expected. Please understand that this will only be an *estimate.* This *estimate* can be extended for 90 days only. Treatment needs can change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the word *estimate* as dental benefits are determined by each patient's dental contract. Every patient's dental plan is different, and necessary dental services are not necessarily covered. Most dental plans are designed to assist patients with their dental expenses. Very few dental plans fully cover all dental services .If your dental plan pays more than expected, you will receive a prompt refund. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determines that you were not eligible for coverage, the balance becomes your responsibility.

We appreciate the confidence that you have placed in us in caring for you and your family. We are available at any time to assist you with your account. Please feel free to contact us with any questions you have regarding your account.

Consent for Services

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by my doctor to make a thorough diagnosis of my dental needs.
- Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I understand that any broken appointments not previously cancelled 24 hours prior to appointment time will result in a $75.00 charge.
- I understand that the doctors DONOT have a contractual agreement with any dental insurance plan to accept dental benefits as payment in full for service rendered. To the extent permitted under applicable law, I authorize release of any information relating to my dental claims. I also authorize payment of dental benefits otherwise payable to me, directly to the office of Avason Family Dentistry.

I have read the above conditions of treatment and payment and agree to their content.

______________________________date: ____________________witness_____________
Signature of patient/guardian

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

You May Refuse to Sign This Acknowledgement

______________________________ I have reviewed and/or been offered to receive a copy of this office's Notice of Privacy Practices.
Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

-Individual refused to sign - Communications barriers prohibited acknowledgement
-An emergency situation prevented us from obtaining acknowledgement