Please read, initial and sign below:

Adult Photograph Consent

_____, being a patient of Doctor David F. Ouellet, I hereby consent to the use and publication of photographs and slides of his treatment of me, and recognize that, on occasion some of these photographs and/or slides may show facial profiles or front views, and waive any and all interest therein.

Child Photograph Consent

_____ being the parent of _____, who is a patient of Doctor David F. Ouellet, I hereby consent to the use and publication of photographs and slides of his treatment of my child, and recognize that, on occasion some of these photographs and/or slides may show facial profiles or front views, and waive any and all interest therein.

Notice of Privacy Practices

_____ I have received a copy of this office's Notice of Privacy Practices. Who would you like us to share your information with? Indicate (h) for health information or (f) for financial information or (a) for all, next to individuals name.

_____

_____

_____

Materials Safety Data Sheet

_____ I acknowledge I have received a copy of the Dental Materials Fact Sheet dated October, 2001.from the office of Pacific Coast Smiles, Dental Office of Dr. David F. Ouellet, DDS., Inc.

After Hours Visits

_____ I am aware if I am in pain or have other dental concerns after regular hours, I am subject to the 'After Regular Hours Visits' fee (currently $203.00), plus the services rendered that day. This fee is subject to change.

Financial Policy

_____ Pacific Coast Smiles offers many options to help you meet your financial/ dental goals – fee arrangements are required at first appointment. Payment in full is expected at each visit. We accept cash, check, Care Credit, MasterCard, Visa, Discover, American Express. We accept insurance on-assignment, as long as your estimated portion is paid in full upon each visit.

Patient Responsibility When Insurance is Involved

_____ I am responsible for knowing what services are covered by my own insurance plan, knowing what doctors I am allowed to see, advising Pacific Coast Smiles of any changes in benefits and insurance changes, and I am responsible for all charges for services rendered regardless of insurance outcome.

Finance Charges Assessed

_____ I understand If my account is not at a zero balance (your portion of the account, not the insurance portion of the account), after ninety (90) days, it will begin to be assessed 10% interest per annum.

There are security cameras located in this office

Patient Acknowledgement _____ Date _____

MISSED OR SHORT CANCELLATION APPOINTMENT POLICY

It is our goal to be as efficient with your time and hard-earned dollars as possible. To help achieve this goal we schedule specific appointment times just for YOU and your family, so that we may promptly serve you. Charts are reviewed prior to your arrival, rooms are disinfected and sterile instruments are set out in the room just for you and your procedures, because we care about how you are served.

When an appointment is failed or short cancellation notice is given, all the instruments must be sterilized again, and everything put back up before we can prepare for the next patient. This is very inefficient and costly. Therefore, we ask for at least 24 hours notice prior to your scheduled appointment time so that we can schedule another person for that time and that you may avoid our $25.00 - $50.00 missed appointment fee.

We realize that on rare occasions, unavoidable emergencies occur and make giving us an advanced notice impossible. We are very understanding of this and will always work with you.

Thank you for your faith and trust in us!

Pacific Coast Smiles

Dental office of Dr. David F. Ouellet, DDS, Inc.

_____ _____

Patient Signature **Date**

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