Ewa Awad D.D.S.
Cosmetic and Family Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

ACKNOWLEDGEMENT OF MEDICAL HISTORY QUESTIONNAIRE COMPLETION

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITY AND OFFICE POLICIES

Notice of Informed Practices

_____ I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices. (HIPAA).

Notice of Medical History Completion

_____ I hereby acknowledge that a complete medical history questionnaire is important for a comprehensive evaluation of my dental health and that I have provided a full and accurate medical history. Furthermore, I understand that the information will be kept strictly confidential. I will not hold Dentex Smile Studio or the staff responsible for any errors or omissions that I have made in the completion of this form.

Authorization for Treatment

_____ I authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of me or my dependent's dental needs.

Photo and Video Consent

_____ I give Dentex Smile Studio consent to use my photo and video for the purpose of patient recognition, treatment presentation or internal marketing.

Missed Appointments

_____ I understand that I must give 48 hour notice for any appointment that I cannot keep. Dentex Smile Studio does not charge patients for missed appointments; however, they reserve the right to dismiss patients who fail to give prior notice.

Financial Policy

_____ I understand that ALL responsibility for dental services provided in this office for myself of my dependent is mine. Payment is due and payable at the time the services are rendered. If insurance is to be used, copay is due and payable at the time services are rendered.

Insurance

_____ I understand that any dental benefit program that I participate in is a contract between my employer, the insurance company, and myself. Dentex Smile Studio is not a party to that contract and

can only file claims as a courtesy to our patients. I understand that all services and fees may not be fully covered by an insurance carrier and that I am ultimately responsible for the payment of ALL dental services provided in this office for my dependents or myself. I understand that Dentex Smile Studio will file the forms necessary to assure I receive the benefit of my dental insurance and will allow 60 days for the insurance company to pay. Any unpaid insurance balance over 60 days will be transferred to my account and due immediately. I realize that failure to keep my account current may result in Dentex Smile Studio being unable to provide additional services. In the case of default on payment on this account, I agree to pay collection fees, returned check fees, administrative and financial service charges, attorney fees, and any other fees incurred in attempting to collect this amount or any future outstanding balances. I hereby authorize direct payment to Dentex Smile Studio of any medical benefits payable to me for the services provided at Dentex Smile Studio.

Payment Options

We want our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment.

- Cash or Debit (with no insurance, must prepay in advance of treatment to receive a discount)
- Check (There is a $35.00 charge for any returned check)
- Credit Card (Visa, MasterCard, Discover)
- Care Credit (For treatment over $300.00 – Please ask our administrative staff for details and credit applications)

I comprehend the information on this form and understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Date_____

Signature of Patient, Parent or Guardian_____

Print Patient, Parent or Guardian Name_____

If not signed by the patient, please indicate relationship:_____

Print Witness Name_____

Signature of Witness_____