WELCOME TO THE OFFICE OF DR. INRI T. HSU

OFFICE POLICIES EFFECTIVE 01/01/2014:

Scheduling/Emergencies

We attempt to provide you and/or your family member with the most efficient and informative appointments. We strive to see all patients on time for their scheduled appointments. Please remember there are times when our schedule is delayed in order to accommodate a patient's need. Please accept our apology in advance should this occur during your appointment.

Appointments/Running Late

Your scheduled appointment time has been reserve specifically for you and/or your family member. While we make every effort to remind you with a courtesy appointment card, phone call and post card of your appointment, your appointment is your responsibility. If a cancellation is unavoidable, please call the office at least 24 hours in advance, this allows us sufficient time to notify another patient needing our care. If you arrive 10 minutes late for you appointment, you may be asked to reschedule for the next available appointment time.

Broken/Rescheduled/Failed Appointments

Any broken, last minute rescheduled or failed appointments affect many people. If you do not call to cancel and fail to show as scheduled to your appointment, **you will be charged a broken/failed to show appointment fee of $25.00.** If you wish to reschedule your appointment, we ask that you give us at least 24 hours advance notice. Cancellations received less than 24 hours will be considered a last minute failed appointment.

If two (2) broken/failed appointments occur or two (2) cancellations without a 24 hour notice, we may request that you seek dental care at another dental office that can better accommodate your schedule. Our office reserves tthe right NOT to schedule any subsequent appointments. All broken appointment fees must be paid before we are able to reschedule future appointments. ***Families who break, fail or reschedule last minute appointments with multiple family members may not be allowed to schedule their appointment on the same day again.**

Insurance

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary greatly, we can only **ESTIMATE** your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Please be aware that your insurance policy is simply an agreement between you and your insurance company and is not a guarantee of payment. Therefore it is your responsibility for what your insurance does not cover. Your **ESTIMATE** patient portion must be paid in full at time of service. A service of 1 ½% per month (18% per annum) will be added to the unpaid balance of all accounts not paid in full within 60 days of the treatment date. If you have any questions our courteous staff is always available to answer them.

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Pecos Dental/Inri T. Hsu, D.M.D. In the event of legal action of this account, I agree to pay any and all cost of such suit, collection and attorney fee. I have reviewed the treatment plan and authorize the release of any information relative to this claim.

Consent for treatment

I do authorize and give consent to Pecos Dental, Dr. Inri T. Hsu, D.M.D and her staff to administer treatment, including but not limited to local anesthesia and other such treatment, which in their judgment, may be necessary for the prudent exercise of medical or dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.

I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.

I consent to the disposal of any tissues or body parts that ma be removed. I acknowledge that no guarantee or assurance has been given to me, by anyone as to the results that may be obtained.

I have had the opportunity to review Pecos Dental Notice of Privacy Practice.

I grant my permission to you or your assignees to telephone me at home, at work or on my cellular to discuss matters related to this consent, my treatment or my account.

Patient Name (Print)	Signature of Patient or Responsible Party	Date