SOUTHERN CONNECTICUT DENTAL GROUP

General, Pediatric & Cosmetic Dentistry

Ansonia Office
497 Main Street
Ansonia, CT 06401
203-735-4701

Southbury Office
30 Quaker Farms Road
Southbury, CT 06488
203-264-4351

www.southernCTdental.com

CANCELLATION POLICY

We are committed to meeting our patients' dental care needs. No-shows and late cancellations waste precious time that other patients could use.

- Please, confirm your appointments by phone, e-mail or text message at least 24 hours prior to your visit.
- All appointments must be cancelled 48 hours prior to appointment.
- If there are 3 no-shows or same day cancellations we reserve the right to dismiss you and your family from our practice.

I received a copy of this policy and understand that I will be financially responsible for all missed scheduled appointments that are not cancelled as described in the policy above.

_____ _____

Patient | parent | legal guardian signature Date

Thank you for your continued support of our practice.

OFFICE POLICY

We ask your cooperation in carefully this information and signing below as indicated.

PLEASE UNDERSTAND THAT ALL CHARGES INCURRED BY A PATIENT ARE THE FULL RESPONSIBILITY OF THE PERSON WHO IS LIABLE FOR THE ACCOUNT.

Due to constantly changing benefits and deductibles, we are only able to ESTIMATE what portion of the of the charges your insurance company will cover. If the insurance company pays less that expected, the difference is your responsibility.

Patients without insurance be advised that payment is expected at the time of your visit.

As a courtesy to those patients who have insurance, we will handle the submission of the insurance claim. Any fees the insurance company has not paid within sixty (60) days of the treatment, but are still pending, are due and payable by the patient.

_____ _____

Patient | parent | legal guardian signature Date

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Southern Connecticut Dental Group Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control this information. By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment of services given to me, and for the business operations of medical group, its staff, and its business associates.

I grant permission for Southern Connecticut Dental Group to disclose my personal health information, including appointment times, treatment plans and financial information, to the following person(s):

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

☐ I do not grant permission to disclose my information to any personal representative(s)

I understand that this permission will remain in effect unless a written cancellation has been provided to Southern Connecticut Dental Group.

_____ _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority