SIRINITY SMILES
FAMILY AND COSMETIC DENTISTRY

TREATMENT CONSENT AND OFFICE AGREEMENTS

	Initial Below
Treatment Consent: I certify that the information provided on the Welcome form to Sirinty Smiles is accurate to the best of my knowledge. By affixing my initials, I authorize Sirinity Smiles to perform the necessary diagnostic procedures and provide the necessary dental care for the named patient below for treatment agreed upon, either written or verbally presented.	
Notice of Privacy Practices: I have received and read this practice's Notice of Privacy Practices. By affixing my initials, I give consent to Sirinity Smiles to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations. I have the right to revoke this consent at any time by written notice. I understand that if consent is not provided, Sirinity Smiles cannot release any information for billing, processing insurance claims, sending appointment reminders, or other purposes according to the law. I also understand that I will be responsible for payment in full at time of treatment for not providing consent.	
Financial Policies: By affixing my initials, I agree to follow the financial policies of Sirinity Smiles, including 1.5% monthly interest for accounts overdue more than 60 days. I understand that I am entitled to a copy of the financial policies and a written estimate prior to commencement of treatment. I am aware that I am fully responsible for all fees incurred regardless of insurance coverage. I also understand that all payment and co-payments are due at the time of service.	
No-show/Late Cancellation Agreement: Here at Sirinity Smiles, we strive to provide you with the most effective and convenient care possible. We value the time scheduled for your appointment because this is time reserved especially for you. With this in mind, we have a policy requiring at least a 24-hour notice for all cancellations. By affixing my intials, I understand that there will be a $50 fee for any cancellations within 24 hours of my appointment and for any no-shows. Emergency situations will be considered on a case-by-case basis.	

Patient Name: _____ (Please print)

Patient Signature _____ Date: _____

Responsible Party Signature (if necessary): _____

Relationship to Patient: _____