



## Evans Street Dental

### COMMITMENT TO APPOINTMENT POLICY

We reserve time for each of our patients in our practice, and rarely do we keep our patients waiting. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and you will be present for that appointment. You must be present for all scheduled appointments. Cancellations or constant short-notice changes affect your treatment sequence and the overall success of your therapy. We require 2 days' notice to be given during our regular office hours (8:00 am – 5:00 pm Monday through Friday) to avoid a \$60 per half hour charge. We realize that unexpected illnesses and emergencies may occur, but we ask for your assistance in this regard. Your signature below indicates that you read our appointment policy.

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Signature

Printed Name

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

## Financial Information

Unless another financial option is pre-arranged, payment in full is due at the time of service. Should a patient have dental insurance, the estimated patient portion will be due at the time of service.

### Payment options:

1. For your convenience we accept cash, check, Visa, Master Card, Discover.
2. We also offer short and long-term financing options through Care Credit. (Interest free options may apply).

### For Patients with Dental Insurance:

Dental Insurance plans often pay less than the actual fee for services, therefore the patient or Guarantor is the responsible party for all dental services provided. After 60 days with no payment from dental insurance the balance becomes the patient's responsibility. Dental Coverage in most cases is a benefit with limitations and should not be expected to take care of all costs. Your Dental Benefits and how they relate to your specific needs will be explained to you before the treatment is started.

### Finance Charge and Fees:

Balances in excess of 60 days are subject to a finance charge of 3.5% per month. Patients who choose a payment plan will be subject to finance charges.

Returned checks are subject to a \$35.00 accounting fee.

## Authorization and Consent for Treatment

### General Consent to Treatment:

I agree and consent to a dental examination by Dr. Ramsay. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done.

### Release of Information:

Because of HIPAA, Federal relations protecting your privacy, we wish to inform you that we will release no information about you without your consent. We are allowed to release this information to your insurance company or as necessary to be paid for our services. You can have access to your records by simply asking. We will give you a copy, if you desire. If you feel we have released information you have the right to file a complaint. The above statement is required by Federal HIPAA regulations.

### Assignment of Insurance Benefits:

I authorize and request my insurance company to pay my benefits directly to Dr. Ramsay.

### Photography/Video Release:

I authorize Dr. Ramsay to take photographs/video of me (my mouth) as to help him and I better understand my current dental condition and possible treatment options.

I understand and will comply with the office CANCELLATION/NO SHOW POLICY.

I understand and will comply with the office FINANCIAL POLICY.

I understand and agree to the GENERAL CONSENT TO TREATMENT.

I authorize the RELEASE OF INFORMATION.

I authorize PHOTOGRAPHS/VIDEO to be take of me by Dr. Ramsay or any of her staff.

I hereby acknowledge that I have received a copy of Evans Street Dental's Notice of Privacy Practices.

I understand that I may ask any questions that I might have regarding this notice.

X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature of Patient, Parent or Guardian