

# The Hygiene Center, LLC

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## Payment Policy

Please understand that the payment of your account is your responsibility and it is considered parts of your treatment. The following is a statement of our payment policy which we require you read and sign prior to beginning your treatment at our office.

1. **ALL PAYMENTS ARE DUE COMPLETION OF YOUR DENTAL APPOINTMENT.** Co-payments and deductible are estimates that must be paid when treatment is completed.
2. For patients that have dental insurance, the costs incurred during treatment are the responsibility of the patient. As a courtesy to you, our office will estimate your co-pay and file your claim. However, any difference our estimate and what your insurance company actually pays will become the sole responsible of the patient.
3. Your insurance is a contract between you and your insurance company, we are not a party to the contract. We can also request a approximately 4-6 weeks to process and it is still not a guarantee of payment by your insurance company.
4. **CANCELLATIONS SHOULD BE MADE 48 HOURS IN ADVANCE. Although we know personal emergencies and situations arise, if you do need to cancel an appointment with less than 24 hours notice there will be \$50 cancelation fee. If you do not show up for your appointment more than 3 times in a 12 month period, you will also be charged a \$50 missed appointment fee before we can schedule your next appointment.**

**Thank You for understanding our payment policies.**

**I have read, understand, and agree to this payment policy.**

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

If you're the Guardian, what is your relationship to the patient: \_\_\_\_\_

## Patient Consent to Perform Dentistry

1. I agree to the use of local anesthesia depending on the judgment of the doctors. There are possible risks and complications associated with the administration of local anesthesia, sedative, and drugs. I also understand that there are rare potential risks such as unfavorable reactions to medication, respiratory, and cardiovascular distress. I understand and have been informed of the above risks and complications.
2. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I will have an opportunity to ask questions regarding the additional or different treatment and risks.
3. I hereby authorize and direct the dentist and/or dental auxiliaries at The Hygiene Center, LLC to perform the following dental treatments as needed after diagnosis and discussion of treatment options with the doctors:
  - A. Preventative Hygiene treatment (Prophylaxis) and the application of topical fluoride.
  - B. Photographs, Radiographs, or other diagnostic aids.
  - C. Application of plastic sealants to the grooves of the teeth.
  - D. Treatment of diseased or injured teeth with dental restorations (Filling or Crowns).
  - E. Replacement of missing teeth with dental prosthesis (bridges, Partial Dentures, Full Dentures).
  - F. Removal (Extraction) of one or more teeth.
  - G. Treatment of diseased or injured oral tissues (Hard and/or Soft).
4. I hereby state that I have read and understand this consent, that all questions about the procedures will be answered in a satisfactory manner. I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

**I have read, understand, and agreed to Consent.**

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Print Name: \_\_\_\_\_

If you're the Guardian, what is your relationship to the Patient: \_\_\_\_\_