OFFICE POLICIES

Thank you for choosing our office for your dental needs. Your smile is our success and we strive to provide you with the best treatment options to achieve oral health.

APPOINTMENTS - LATE CANCEL AND NO SHOW

We understand that your time is valuable; for this reason we reserve and confirm a time slot in our schedule just for you. In order for us to maintain a high level of service we ask that you give us at least 48 hours notice if you cannot make your scheduled appointment.

If you fail to give us at least 48 hours to cancel an appointment or do not show up you will be charged a no-show/late cancellation fee of $50.00. **We keep a credit card number on file that will be charged in this event.**

We do recognize that urgencies arise and you cannot always give us advance notice but we respect your time and ask that you do the same for us.

If you late cancel or no show three or more appointments we will still see you in our office but only as a same-day appointment. In other words if you call to schedule an appointment it can only be for the day you call unless it is an emergency.

APPOINTMENTS - LATE ARRIVAL

Recognizing that time is valuable we schedule your appointment based on the procedure that is to be accomplished. If you are more than 15 (fifteen) minutes late it is up to the discretion of the provider (dentist or hygienist) to reschedule your appointment for another date and time.

If you know you are running late please do us the courtesy and let us know. We are usually able to work with you to accommodate a late arrival if we have adequate warning.

FINANCIAL POLICY

Our office provides care to both patients with and without dental insurance. Whichever category you are in you are financially responsible for treatment provided to you or your legal dependent. Payment is due on the day of service and can be made with cash, check or credit card (Visa, MasterCard, Discover or American Express). In addition we take CareCredit, which is a third party dental credit card. Our front office can assist you with making an application for this card.

INSURANCE

Please know your policy. As a courtesy to you we will bill your insurance first. Co-pays and fees are payable on the day of service. You will be given a copy of our fees and your estimated co-pays for each procedure done. Please understand these are estimates and not a guarantee of payment or coverage by your insurance.

If we do not participate in your insurance program we can still bill as an "out of network" provider. This will often mean you may be responsible for additional fees or the difference between our usual and customary fee and what your insurance covers.

PAST DUE CHARGES, RETURNED CHECKS OR BALANCES ON THE ACCOUNT

If there is a balance on your account or a check returned for non-sufficient funds, a statement of charges will be sent to your mailing address and you may receive a phone call from this office to assist in recovery of those funds. If your insurance plan has not paid the claim within 60 (sixty) days, your balance will show as past due. We will then ask your assistance to collect the balance or may ask that you pay us and pursue collection from your insurance for your personal repayment. If a check is returned to us there will be a $25 processing fee and we will ask that all the charges (original fees and processing fee) be paid by credit card or cash.

By signing this form you authorize us to submit claims for payment of dental treatment provided by this office and acknowledge your understanding of the financial responsibility, our late cancellation and no-show policies and accept the responsibility associated with those policies.

I _____ (print name) have read, understand and agree to the office policies listed above. I will present my insurance, if any, and will abide to all financial policies and responsibilities associated with any account associated with my legal dependants or myself.

_____ _____

(signature) (date)

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Debra Araujo, DDS to take radiographs, study models, photographs or any other diagnostic aide she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examination rendered to my insurance company, consulting professionals or others that may require my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of patient or Authorized responsible party	Relationship	Date

HIPAA Acknowledgment of Notice of Privacy Practices

I, _____ (full name), have received or reviewed a copy of the Debra J Araujo, DDS Notice of Privacy Practices.

Signature _____

Date _____

CONSENT TO RECEIVE TEXT MESSAGES

With your consent, the dental office of Debra J Araujo, DDS would like to send text (SMS) messages to the mobile number you have provided in our records.

By providing your informed consent, you acknowledge that you have understood the purpose and agree to participate in our text (SMS) messaging service.

Purpose and Description: Text (SMS) messaging service is designed to provide you with helpful information, reminders, and notifications via text messages sent to your mobile phone. We may use text (SMS) messages to communicate with you for a variety of purposes, including (but not limited to) scheduling appointments and their purpose, medication reminders, payment reminders.

Signature _____

Date _____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____, acknowledge that I have received or reviewed from Debra J Araujo, DDS a copy of the Dental Materials Fact Sheet.

Signature _____

Date _____