Gage Center Dental Group, PA

Informed Consent and
Acknowledgement of Receipt of Notice of Privacy Practices

1) I, _____ have received and reviewed a copy of your dental practice's privacy, security and breach notification policies and procedures. I understand that I should ask your dental practice's Privacy Official if I have any questions about these policies and procedures.

2) Please list below the full names of people with whom you give Gage Center Dental Group, PA authorization to discuss your case i.e. health history, medical, treatment, appointments, finances etc. Ex: spouse, parent, child, sibling, friend, caretaker, interpreter.

_____ _____

_____ _____

_____ _____

3) Please provide an updated emergency contact:

Name:_____ Phone:_____

4) Gage Center Dental Group, PA may communicate with me electronically at the email address below. I am aware that there is a level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address.

_____@_____

_____@_____

5) Your appointment time is reserved specifically for you. Failure to keep an appointment without notifying our office 24 hours in advance may result in a missed appointment charge that is not covered by insurance. If you are more than 10 minutes late for your appointment we may need to reschedule.

6) Payment is due at the time of service. We pre-authorize treatment and file insurance claims as a courtesy to our patients. The patient is responsible for their portion of the costs at the time of the appointment regardless of what insurance may or may not pay.

7) The parent/guardian accompanying a minor to appointment is financially responsible for the account.

8) 1.5% per month will be added to charges on accounts not paid within sixty days after the date of treatment. This periodic rate equals an ANNUAL PERCENTAGE RATE OF 18%. In the event of default the patient will pay all collection charges and/or attorney fees to recover unpaid balances.

I hereby grant permission to the staff of this office to administer such medications and anesthetics and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

SIGNATURE_____ DATE _____

As a courtesy, please silence your phones once you have been called in the treatment room.