



Payment Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, MasterCard, Visa, American Express, Discover, and CareCredit (outside financing upon approval).

For our patients with Dental Benefits; as a courtesy to you we will help you process all your insurance claims.

All charges you incur are your responsibility regardless of your insurance coverage.

If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

I AUTHORIZE ONCALL DENTAL URGENT CARE TO BILL MY INSURANCE COMPANY AS WELL AS ALLOW MY DENTAL BENEFITS TO BE PAID DIRECTLY TO ONCALL DENTAL URGENT CARE.

X

PATIENT SIGNATURE (PARENT/GUARDIAN OF MINOR)

DATE

HIPAA/Privacy Rule

A major goal of the HIPAA/Privacy Rule is to assure that individuals' health information is properly protected while still providing the highest quality of dental care. OnCall Dental Urgent Care will not release any information without the authorization of the patient. Under the HIPAA laws OnCall Dental Urgent Care is authorized to share needed information to the patient themselves, guardians, insurance companies, primary care physicians as well as law enforcement agencies.

I give the following people (listed below) access to my dental records.

(Indicate One): I give / don't give permission to leave messages on voicemail.

Your signature on this form certifies that you have read and understand the privacy laws.

X

PATIENT SIGNATURE (PARENT/GUARDIAN OF MINOR)

DATE



Treatment Consent

I do hereby acknowledge, agree, and give my voluntary consent for treatment provided through OnCall Dental Urgent Care as may be deemed necessary or desirable by my treating professional(s), their assistants, and/or designees. This authorization includes, but is not limited to, routine diagnostic procedures, outpatient care, laboratory tests, and x-rays. I understand that my treatment may include a variety of interventions. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at the office. I acknowledge that my care is under the direction of my treating professional(s) and I represent that I will follow the instructions of my professional(s) in the provision of said care. Before receiving treatment you should ask the dentist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result of cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

X _____
PATIENT SIGNATURE (PARENT/GUARDIAN OF MINOR)

DATE