## COMMUNICATION CONSENTS EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Patriot Dental Snead offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Patriot Dental Snead will use reasonable means to protect the security and confidentiality of email information sent and received. However, Patriot Dental Snead cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Patriot Dental Snead and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Patriot Dental Snead.

## TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information and for Billing Purposes. Patriot Dental Snead, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Patriot |Dental Snead will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Patriot Dental Snead cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Patriot Dental Snead and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Patriot Dental Snead.

## MISSED APPOINTMENTS

Unless we receive notice of cancellation 24 hours in advance, you will be subject to a $50 cancellation fee. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement. I understand that I am ultimately responsible for all fees rendered to me and/or my family.

## FINANCIAL POLICY FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

## INSURANCE

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions

concerning the treatment and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
As the patient, I understand the following terms:
Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.
If there is dental insurance on my account, I understand that the office has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.
Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included in the total.
Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.
As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. Our office will make an effort to anticipate any changes in the treatment plan and advise you at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

**PAYMENT**

We make every effort to keep down the cost of your dental care, which requires us to promptly collect payment for our services to avoid additional costs. Please come prepared for this contingency. We accept cash, personal checks, Visa, Mastercard, Discover, Care Credit and American Express. Feel free to ask about the cost of treatment when you schedule the appointment. If your treatment program is extensive and requires several visits, you will be given an estimate and encouraged to discuss definite financial arrangements with a member of our business office staff.
ANY UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

Patient's signature: ________________________________ Date: ________________________