CENTER FOR
RESTORATIVE, COSMETIC
& IMPLANT DENTISTRY

Patient Consent

560 Kempsville Rd, Suite 200
Chesapeake, VA 23320

825 Battlefield Blvd, S
Chesapeake, VA 23322

303 35th Street, Suite 103
Virginia Beach, VA 23322

Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes, etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family will feel welcome to our dental family.

DENTAL INSURANCE - Dental insurance is filed as a courtesy. Current dental information must be provided prior to receiving dental services. By signing below, you understand and agree that you are responsible for all co-pays (if applicable) and all balances due. Our office is a third party with all involvement with your dental plan. Our staff assists with information as available to our office; however, the policy holder is ultimately responsible for knowing the limitations of their dental plan.

ELECTRONIC CLAIMS SUBMISSION – We submit insurance claims immediately, and electronically, when allowed by the insurance company. If your insurance company has not made a payment within 30 days of billing, the balance will become your responsibility.

PAYMENT IS DUE WHEN TREATMENT IS RENDERED - We accept Cash, Personal Checks, VISA, Mastercard, American Express, and Discover Card. We also accept CARE CREDIT.

MONTHLY PAYMENTS – An in office 90-day payment plan can be arranged with a credit card on file. This must be set up with the office prior to treatment. First installment on the date services are performed. In the event of a default of payment or rejection of payment by your financial institution, the balance becomes due immediately and all prior financial arrangements are null and void.

BILLLING STATEMENTS - Patients with outstanding balances will receive a statement. We reserve the right to charge a finance charge of 1.5% (18% APR) for accounts over 60 days past due. Return check fee is $50.00.

APPOINTMENT CANCELLATIONS AND CHANGES - We request 48 hours notice to cancel or reschedule an appointment. We reserve the right to charge a minimum fee of $35.00 up to the amount of the proposed treatment scheduled for a broken appointment with less than 24 hours notice.

SIGNIFICANT EXPOSURE- Section 32.1-45,1(A) and (B), Code of Va. (1950, as amended) provide that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus, Hepatitis C Virus, or any other communicable disease, is considered to have been given by the patient and/or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

MINOR PATIENTS- The adult accompanying the minor is responsible for the payment on the account. No minor is permitted to receive treatment without the accompaniment of the minor child's parent, guardian, or appointed caregiver present at the time of treatment.

NO GUARANTEE OF RESULTS - Dental treatment is not an exact science. By signing below, you understand that no guarantee or assurance has been made as to the results which may be obtained from the exam, testing, and/or treatment.

CONSENT FOR TREATMENT - I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the rendering dentist or staff member under the direction of the rendering dentist. I will be informed of options/reasons for treatment and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to the dental practice. I further consent to the taking of photographs for treatment, documentation, and/or payment purposes.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles, or non-covered services. I understand in the event my account becomes delinquent I will be responsible for any collections, attorney fees, court costs, interest (and any other charges incurred to collect this account) on the principal balance of 18% per annum from the date of service. In the event the account is turned over to collections you will need to discuss all payment arrangements with our collection service.

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Signature of Patient/Guardian/Parent **Date**