INTEGRATED
DENTAL ARTS

Please read and initial each of the following paragraphs

Consent of Care

_____ I hereby agree and give my consent for Integrated Dental Arts to provide dental care that is considered necessary and proper in diagnosing or treating my dental condition. I understand that during RESTORATIVE treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary in the best interest of my oral health. Our staff will notify patient of any changes to treatment before proceeding with care.

Benefit Assignment/Release of Information

_____ We may accept assignment of insurance benefits, however the **balance** is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your correct complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That **patient balance** is due at time of service.

Appointment Reminders and Cancellation Policy

_____ **In addition to phone calls**, appointment reminders will be sent by email and via text. A reminder call will be made the working day before your appointment as well. Please indicate which you prefer:

Email Text

_____It is the patient's responsibility to give Integrated Dental Arts a 24 hour notice if they will be unable to attend an appointment. It is Integrated Dental Arts policy that patients who fail to give 24 hour notice will be charged a $25 no-show fee. This policy makes it possible for Integrated Dental Arts to offer appointments to all patients in a timely and effective manner.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on Integrated Dental Arts' website. In addition, I acknowledge I can request a copy of Integrated Dental Arts Notice of Privacy Practices in writing at any time.

Photo and Testimonial Release

_____ I, hereby grant permission to Integrated Dental Arts to use my photograph and any testimonial I give regarding the dental care I receive in any marketing, advertising or teaching materials used to market or advertise this dental practice, including Integrated Dental Arts' website. I acknowledge that Integrated Dental Arts has the right to crop and otherwise treat the photograph at their discretion. I also acknowledge Integrated Dental Arts may choose to not use my photograph or testimonial at this time, but may do so at a later date. I further understand that if the photographs, slides and video no other identifying information will be used unless stated differently. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature:_____