Smilesavers
Dental
Dr. Lopa Shah. DDS
1214 Apollo Way #402, Sunnyvale, CA 94085.
www.smilesaversdental.com
408-737-0101

Patient Name:

Consent for work to be done today:

Today's visit consists of a complete oral exam and full x-rays. If possible, after Dr. Shah evaluates what is necessary for the patient, Dental cleaning and fluoride will be done.

Signature of Patient or Parent/Guardian if patient is a minor **Date**

Acknowledgement of Receipt of Notice of Privacy Practices:

I Acknowledge that I have received a copy of the Dental Practice's HIPPA Notice of Privacy Practice and Material Fact Sheet dated October 2001. I understand that if I wish to receive a personal copy I can ask for one.

Signature of Patient or Parent/Guardian if patient is a minor **Date**

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because;

___Individual refused to sign.
___Communication barriers prohibited obtaining the acknowledgement
___An emergency situation prevented us from obtaining acknowledgement.
___Other (Please Specify)

Missed Appointments Fee: $25/hr

Smilesavers Dental has a missed appointment fee. Missed appointment fee constitutes any appointment for which the patient does not show up. Smilesavers Dental will waive the missed appointment fee if the patient cancels their appointment 24 hours before the scheduled appointment time.(Calling the night before the appointment does not satisfy the 24hour cancellation policy.)

Missed appointments place a burden on our practice by wasting the Doctor's time, preparation by the staff, and taking away appointment time from other patients.

NO EXCEPTIONS!

I have read this missed appointment policy and agree to its regards to all of my appointment at Smilesavers Dental.

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Initials:_____ Phone Messages

We may use and disclose medical information to contact you and/or remind you about appointments. If you are not home or unavailable on your mobile device, we may leave this information on your voicemail or leave a message with the person answering the phone.

Initials:_____ E-mail communication/Billing Statements

We may use e-mail and disclose medical and **BILLING** information to contact you and remind you about appointments and/or Bill you for any pending balance after insurance payments are made.

Initials:_____ Photo Release

I grant permission and consent to Smilesavers Dental for the use of any photographs taken with or of me. These include but not are not limited to: publicity, copyright purposes, illustration, advertising, and web content.

Initials:_____ Financial Policy

Thank you for choosing us as your healthcare 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, agree to and sign prior to any treatment.**

All patients must complete our patient information form before seeing the doctor.

Full payment is due at time of service. Partial payment may also be accepted depending on the total amount. Please ask for details.

We accept cash, check, and credit cards (Visa and MasterCard only) any returned check is subject to $100 penalty charge regardless of the amount date.

We do offer an extended payment plan with prior credit approval.

Intials:_____Adult Patients/Parents/Guardian/Minors:

Adult Patients/Parent/Guardian is responsible for full payment at time of service.

The adult accompanying a minor and the parents (or guardians) are responsible for full payment for unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard or payment by cash or check at time of service.

Initials:_____ Finance and late Charges:

Please note that any payments not received within 30 days of treatment will accrue interest at the rate of 1.5% a month in addition to late charges of $25 per month(starting at date of service).

I HAVE READ, UNDERSTOOD AND AGREED TO THE ABOVE FINANCIAL POLICY.

Patient Name **Signature of Patient or Parent/Guardian if patient is a minor** **Date**