TYMA, TRACHTENBERG
BULLOCK & BLESSINGTON

Center *for* Contemporary Dental Health

Patient Acknowledgments

- I understand that all charges incurred are payable in full at the time of service. Please refer to the written financial policy for full payment details.
- We reserve time specifically for you and take pride in our prompt schedule. Patients are expected to notify the office at least 48 hours prior to their scheduled appointment if they cannot keep the appointment. Three non-notified missed appointments may result in dismissal from the practice.
- I understand that the use of anesthetic agents embodies a certain risk. Every treatment carries some statistical risk which may result in injury, even if performed with the utmost care, and that not all dental procedures produce an ideal result.
- I grant my permission to the staff of Tyma Trachtenberg Dental to telephone me at home, my work or another phone number provided to discuss matters related to treatment.
- I agree to the staff of Tyma Trachtenberg Dental to contact me at the email address provided to discuss matters related to treatment or appointment reminders.
- I grant my permission to the practice of Tyma Trachtenberg Dental to upload and store confidential patient information (including account, appointment, clinical and personal information including email addresses) to the practice's secured website. I understand that, for security purposes, the site requires a user ID and password for access and use. I also am aware that this practice and myself are responsible for maintaining the strict confidentiality of any assigned ID and password.
- I consent to the taking and sharing of radiographs and/or photographs before and during treatment for diagnostic purposes.
- I consent to the sharing of radiographs and clinical information with dental and/or medical specialists who are invited to participate with my treatment.
- With whom do you authorize us to discuss your dental health information?

_____ _____

Name/Relationship *Phone Number*

_____ _____

Name/Relationship *Phone Number*

_____ _____

Patient, Parent or Guardian Signature *Date*

_____

Patient Name (Please Print)

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Financial Agreement

Thank you for choosing Tyma Trachtenberg Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Please contact the office at any time with questions regarding your financial responsibility.

- **Payment** : Fees for services required are due prior to or at the completion of your treatment. Payment may be made in cash, check, or credit card (Visa, MasterCard, American Express or Discover Card). We also offer monthly payment plans through CareCredit, subject to credit approval. A 5% courtesy accounting adjustment is available to patients who pay for their treatment with cash or check prior to initiation of care for treatment plans of $5,000 or more.
- **Insurance** : For patients with dental insurance we are happy to work with your carrier to offset the cost, and provide you with the documentation you need to receive reimbursement for your treatment. Payment is expected at the time of your visit.
- **Refunds** : If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
- **Returned Checks** : A $25 processing fee will be charged for a returned check.
- **Interest** : Any account remaining unpaid 30 days from date of service will be charged interest at the rate of 1.5% per month on any unpaid balance unless prior payment arrangements have been approved.
- **Non-Payment** : In the event the charges incurred are not paid in full when due, collection action may be taken after 90 days.

Financial Responsibility Agreement

I have read the financial responsibility for dental services, agree to the terms, and accept full responsibility for all charges for services rendered.

_____ _____

Patient, Parent or Guardian Signature *Date*

_____

Patient Name (Please Print)

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Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this agreement.

A hard copy of the Notice of Privacy Practices can be obtained at the offices of Tyma Trachtenberg, and it is also available on our website.

I , _____ , have received a copy of this office's Notice of Privacy Practices.
Patient Name (Please Print)

_____
Patient, Parent or Guardian Signature

_____
Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please specify)

_____

_____

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