West Chester Family Dentistry
9000 Cincinnati Dayton Road, Suite 200
West Chester, Ohio 45069
513-755-2118
www.wcfamilydentistry.com

Section A: Consent to Treatment

I do hereby authorize and request the performance of dental treatment for me by West Chester Family Dentistry and any procedures deemed necessary for treatment. I understand your team will use clinical and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics and analgesics deemed advisable. I understand any treatment plans presented, along with associated fees, may change depending on time lapse from initial examination and diagnosis and actual treatment rendered date. Once treatment has been started, complications may arise, which require additional procedures and/or treatment.

Section B: Reservation Policy

Office appointments are considered reservations and time is reserved specifically for me. Once I reserve time with West Chester Family Dentistry, I understand that it is considered confirmed. I will receive a text, email or courtesy calls reminding me of my reservation. **We ask for a 48-hour notice of all cancellations/reschedules, or a fee of $25 per every half hour for length of appointment scheduled may be assessed.**

Section C: Financial Policy

I understand and agree to my responsibility for all charges incurred regardless of insurance coverage. West Chester Family Dentistry has accepted the insurance company's verification of coverage and benefits in good faith and expect the claim to be covered as described. In the event the insurance company does not cover the claim, according to verified benefits, I understand I am responsible for all charges I, or my dependents, have incurred. I agree to respond to insurance requests efficiently to ensure a quick reimbursement. I hereby assign all benefits, otherwise payable to me, to the office of West Chester Family Dentistry as well as the release of any information relating to my claims or my dependent's claims. Insurance is a method of payment and not a method of treatment. I understand my employer has a contract with the insurance company and they determine the amount reimbursed for each procedure. The West Chester Family Dentistry team is more than happy to consult with you on insurance optimization. After 60 days, if the claim has not been paid by insurance, the balance is due. West Chester Family Dentistry collects fees associated with interest on past balances, collection agencies, and returned checks; $35 is added to the balance of the returned check. We accept cash, personal checks, Visa, Mastercard, Discover, American Express, Lending Club and Care Credit.

Section D: HIPAA – Notice of Privacy Practices & Disclosure of Health Information

Notice of Privacy Practices are available upon request to read and consider the contents. This notice provides a description of treatment, payment activities and healthcare operations, uses and disclosures made of your protected health history and information, as well as important matters about your protected health information. By signing this form, I am giving consent to release and disclose my protected health information as described on the Notice of Privacy Practices to carry out treatment, payment activities, and health care operations.

Section E: Photo Consent

I agree to have a photo taken of me for internal office use only. I also agree to have photos taken of my face, jaws and teeth (before and after) as an educational tool. I understand if my photos are used in any publications or as part of a demonstration, my name or other identifying information will not be used. I also do not expect compensation, financial or otherwise, for use of my photos.

Patient Signature: _____ Date: _____