ALL PATIENTS MUST COMPLETE OUR INFORMATIONAL, FINANCIAL, AND INSURANCE FORMS BEFORE SEEING THE DOCTOR.

Full Name: _____ Birthdate: ____/____/____ Address: _____City, State, Zip:_____

Cell Phone: _(_____)_____ Other Phone: __(_____)_____ Email: _____Social Security #: _____

OFFICE AND FINANCIAL POLICIES OF FOUR CORNERS DENTAL AND DENTURES

_____ During the course of treatment, medication may be necessary. I understand that antibiotics can interfere with the effectiveness of contraceptives. Pain medication, anesthesia, antibiotics and other medication can interact with other medications I may be taking and/or they can cause allergic reactions such as swelling of tissues, pain, itching, rash, vomiting, and/or anaphylactic shock.

_____ I understand that dentistry is not an exact science, and therefore no guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

_____ I acknowledge that my treatment plan is an estimate only and it is the patient's responsibility to pay for any additional treatment. I am welcome to ask questions about any aspect of my dental care and will request information if I am confused or need more information. I understand that I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ **Appointments-** Our Office requires 48-hours advance notice for cancelling or rescheduling appointments. I understand that if I arrive late, I may need to be rescheduled. If I fail to show up for my appointment or cancel within 48 hours, I will incur a $75 fee that must be paid before scheduling further treatment. I also understand that I may be dismissed from the practice for missed appointments.

_____ **Billing & Payments** – I understand payment in full is required at time of service, regardless of pending insurance. Returned checks will be charged a $40 returned check fee, which must be paid by cash or money order before future treatment will be allowed. I understand all accounts not paid in full at time of service will incur a $5 billing charge each month until the balance is paid. Balances which are 30 days old or older will also incur a monthly 1.5% finance charge which equals an 18% per annum rate. Any account that has not received payment in 60 days will be handed over to a collection agency. I understand that this will negatively impact my credit history and limit the treatment I can receive at our office. I know that I will be responsible for any collection costs that may arise.

_____ **Insurance** – If I have dental insurance, I understand that the office will file a claim as a courtesy to me, but payment in full is still required at time of service (with the exception of Colorado Medicaid). If Four Corners Dental and Dentures receives a check from my insurance company, a refund check will be sent to me. I understand that if my insurance company has not paid my account in full within 60 days (including Medicaid), the balance will be automatically transferred to my account and remain my responsibility. It is my responsibility to provide accurate insurance information to the office, to be aware of my coverage and benefits, and to discuss insurance matters directly with my insurance company.

_____ **Refunds** – I understand that Four Corners Dental and Dentures does not offer refunds for their services.

By signing below, I consent to be a patient of Dr. James Moore or associates of Dr. Moore and agree to a radiographic and clinical exam. I acknowledge that I have reviewed the informational, office and financial policies of Four Corners Dental and Dentures and understand the information. I accept full financial responsibility for my dental treatment and allow the release of information needed to have my insurance claims be processed (if necessary). I also understand it is my responsibility to Inform the office on any changes in my health, medications, insurance, or contact information.

Patient Signature: _____**Date:** _____

I have had the opportunity to view the most current **Notice of Privacy Practices.** I have either received or declined a copy, but acknowledge that one has been offered to me.

Patient Signature: _____ **Date:**_____