Office Policy and Consent Form

I hereby authorize "Fatemi Family Dentistry, LLC." to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical and dental information for this or any related claim to my insurance carrier.

This authorization may be revoked by me or my insurance carrier at any time in writing. A copy of this authorization may be used in place of the original.

Major dental work policy (crown, veneers, bridge, partial dentures, full dentures)

We stand behind our treatment only when the patient is seen on a regular basis and is under our regular care every six months, or as recommended by the doctor.

Any work that will require one hour appointments and/or may cost more than $300.00 will require a deposit of $100.00 per blocked hour before that appointment can be arranged. When you arrive to your appointment, that deposit will go towards your treatment. We require a 48 business hour advance notice of cancellation. You may not cancel your appointment during the weekend since we cannot fill that appointment time.

I understand and agree that I am financially responsible for charges not paid by my insurance company. Charges not paid within 90 days by insurance company will be made "patient responsible." I further agree in the event of non-payment, to be responsible for the cost of collections, and or court costs and any reasonable legal fees should this receive. I understand that returned checks will result in a $25.00 penalty.

Patient Signature: _____Date: _____

Authorization for photographs

I hereby authorize Fatemi Family Dentistry, LLC., their doctors, and their employees to take photographs of my dental conditions. These photographs may be used to aid in communication with a dental lab, other dental care providers, insurance companies, or for internal marketing purposes.

I understand that I can revoke this authorization in writing at any time.

Patient Signature: _____Date: _____

Acknowledgement and Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgment)

___I read Fatemi family dentistry's notice of privacy and don't require a copy.

___I have received a copy of Fatemi family dentistry's notice of privacy practices.

Patient Signature: _____ Date: _____

We attempted to obtain written acknowledgement of receipt of our notice of privacy practice, but it could not be obtained because

___Individual refused to sign

___An emergency situation prevented us from obtaining acknowledgement

___Communication barriers prohibited obtaining acknowledgement

___Other (please specify on back)