Mark Arooni DDS
General Dentistry Informed Consent form

Patient Name: _____

1. Work to be done

I understand that I am having the following work done: ( ) Anesthesia, (X) X-rays Initials_____

2. Drugs and Medications

I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Initials_____

3. Changes in Treatment

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/ all changes and additions as necessary to the success of my treatment. Initials_____

I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the success of dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.
I hereby authorize any dentist or dental auxiliaries of Lakeview Dental Care, P.C. to proceed with and perform the dental treatments and restorations as explained to me. I understand that this is only an estimate subject to modification due to unforeseen or undiagnosable circumstance that may arise during treatment. I understand that regardless of any dental insurance I may have, I am responsible for payment of dental fees. If the patient or responsible party defaults in payment, Lakeview Dental Care, P.C. may exercise all rights and remedies allowed by law, including the right to hold the patient liable for damages, which are, the unpaid balance, collection fees, and possible attorney fees.

Patient or Responsible Party Signature_____ Date_____
Signature of doctor_____ Signature of witness_____

I hereby give permission for the use of dental records including photographs, made in process of examinations or treatment, for purpose of professional consultation, research, education, website, or publication in professional journals.

X_____ Date_____
Patient or Responsible Party Signature

Cancellation Policy

-----Our time is very important to us and our patients. If you are unable to keep an appointment, we expect a minimum of **48 hour** notice. Should a failed or short notice cancelation occur, you will be charged a **non-refundable cancellation fee of $50.00** and full pre-payment of services for future appointments.

X_____ Date_____
Patient or Responsible Party Signature

Payment Polices

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies in our office. Payment is required for all services at the time they are rendered unless you are a member of a dental plan, or insurance, with which we participate. For those patients, applicable co-payments, co-insurances and deductibles will be collected before the time of service. We accept payment in form of cash, MasterCard, Visa, America Express, Discover, Care Credit and debit cards. We will bill your dental insurance plan for you as a courtesy. In the event they do not render payment, you are responsible to pay the balance on the account. Should your account be turned over to collections, a collection fee, and any additional legal fees will be added to your balance. Your signature below signifies your understanding and willingness to comply with this policy.

Authorization to receive payment

I authorize the release of medical/dental information to my primary care, referring doctor, or to any dental specialist if needed and as necessary to process insurance claims and prescriptions. I also authorize payment of medical/dental benefits to the physician.

X_____ Date_____
Patient or Responsible Party Signature