

TOTAL DENTAL HEALTH

Paul S. Linnemann, DDS

OFFICE POLICY CONSENT FORM

Please initial and sign (where applicable) after reading each item:

_____ **OFFICE HOURS**

Monday, Tuesday, Wednesday, 8:00 to 5:00. Friday's hours are 7:00 to 4:00.
Thursday by appointment only

_____ **EMERGENCY CARE**

We provide emergency care for our patients. Calls received early in the day will usually permit us to arrange for emergency treatment that day. Should a problem occur after office hours or on the weekend, please contact us at our emergency phone number, which will be listed on our answering machine.

_____ **FINANCIAL POLICIES**

- Payment will be collected on the day services are rendered.
- Our office accepts Cash, Check, MasterCard, Visa, and Discover
- For fees in excess of \$300.00, payment arrangements will be made in advance.
- A service fee of \$30.00 will be applied for all returned checks.
- Delinquent accounts will be released to a private collection agency. The collection agency charges 35%. This will be added to the delinquent balance when turned over to them.

_____ **DENTAL/MEDICAL INSURANCE**

As a courtesy to our patients, we will submit your insurance claims for you. We require a copy of your insurance and all insurance forms filled out completely. **I authorize my insurance carrier to make payments directly to the Doctor.** We stress that insurance is an agreement between the individual and their respective insurance company. The ultimate responsibility of payment for professional services remains that of the patient.

PATIENT SIGNATURE/Representative _____

_____ **OFFICE CANCELLATION POLICY**

Out of respect to all of our patients, our office has established a 24 hour cancellation policy for all hygiene and doctor appointments. We would appreciate your cooperation on this matter. If this is a repeat occurrence a \$35 cancellation fee will be added to your account.

_____ **GENERAL INFORMATION**

I authorize the Doctor to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated as we mutually agree upon.

_____ **PUBLICATION OF RECORDS**

I authorize that my dental records, slides, photographs, x-rays or any other information pertaining to my treatment be used for advancement of dentistry. These records may be used for teaching or internet purposes. My identity will not be revealed to the general public.

_____ **HEALTH INFORMATION PRIVACY PROTECTION ACT**

I have read and understand the Privacy Policy for this office.

I verify that I have read and do agree to abide by the office policies set forth above.

Patient Signature/Representative _____ Date _____

Witness _____