# Alfred Phen, DDS and Irene Kan, DMD

## CONSENT FOR TREATMENT AND OFFICE POLICIES

I hereby authorize the doctor or designated staff of Dr. Phen, DDS and Dr. Kan, DMD, to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs and that these records may be used for diagnostic and educational purposes.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I hereby authorize payment directly to Dr. Phen, DDS and Dr. Kan, DMD, of the group insurance benefits otherwise payable to me.

I authorize the use of email and/or electronic messaging to contact me with respect to my dental care.

## Failed Appointments/ Last Minute Cancellations

While we do recognize that emergencies occur. When a patient fails an appointment or gives last minute cancellation notice, we do not have time to call in another patient. If you cannot keep an appointment, please give us at least 2 business days notice; and in the event of an emergency, please give us the maximum notice possible. This makes it possible for us to schedule another patient who needs dental care. Patients who fail to show up for schedule appointment or who cancel with less than 48 hours notice may be subject to cancellation fee of $30.

## DENTAL INSURANCE

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit consignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans. Because the insurance policy is an agreement between you and your insurance, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reas your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand the PAYMENT IS DUE AT THE TIME OF SERVICE. In the event payments are not received, I understand that a 1 1/2% late charge per month (18% APR) may be assessed to my account. In the event of default of this account, I hereby agree to pay all costs of collection, including but not limited to, collection company fees, attorney's fees and court costs. I further waive all rights of exemption as to property, both real and personal. I give permission to release my employment status to a representative of Dr. Phen, DDS and Dr. Kan, DMD if needed.

## Payment Options

We accept Visa, MasterCard, Discover Card, American Express, Check and Cash. In addition we offer no interest payment plans and have extended payment plans available. (Subject to credit approval). Please ask front office for a brochure about payment options.

I have read, understand and accept the terms of the above outlined consent and policies.

Patient's Signature: ______________________________ Date: ________________ Witness: ________________________

Parent/Responsible Parties Signature: ____________________________ Relationship to Patient: ________________________