

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Social Security # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Legal Name

Wished to be called \_\_\_\_\_

Responsible Party \_\_\_\_\_  
Name/Relationship

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Married  Widowed  Single

Minor  Separated  Divorced

Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

How did you hear about our office?  
\_\_\_\_\_

## 2 INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_

Subscriber's ID or SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is there any additional dental insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by medical insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I understand that Dr. Stephen E. Burch does not participate with any insurance companies and that reimbursements will come to me directly from the insurance company.

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3 CONTACT INFORMATION

Home (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_  
Used for Confirming Appointments

E-mail Address \_\_\_\_\_  
Used for Confirming Appointments

# 4

## DENTAL INTERVIEW

Fear, Trust, Time, Money, Urgency

D I S C

Date of Last Dental Visit \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

Do you want your teeth to last a lifetime?  Yes  No

How healthy would you like us to help you get your mouth?  Ideal  Average  Don't really care

Are you happy with the appearance of your teeth/smile?  Yes  No

What would you change? \_\_\_\_\_

If we mutually decide that you need some dental treatment, how soon would you like to initiate it?

When a condition is not ideal  When a condition is beginning to worsen  When the condition hurts or breaks

Does your mouth function properly?  Yes  No

Are you fearful?  Yes  No Rate your fear level 1-10 \_\_\_\_\_

Reason for the fear?  Needles  Smell  Sound  Fear of Pain  GS  Triaz  Both

Do you know we provide in-office financing?  Yes  No

Did you have any finance concerns?  Yes  No

What are your financial concerns? \_\_\_\_\_

Special time frames? \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Clenching teeth  Yes  No

Clicking or popping jaw  Yes  No

Fingernail biting  Yes  No

Grinding teeth  Yes  No

Headaches  Yes  No

Jaws pain or tiredness  Yes  No

Lip or cheek biting  Yes  No

Orthodontic treatment  Yes  No

Pain around ear  Yes  No

Sensitivity to biting  Yes  No

Sensitivity to hot, cold, sweets  Yes  No

Vertigo  Yes  No

Ringing in the ears  Yes  No

Bad Breath  Yes  No

Bleeding gums  Yes  No

Dry mouth  Yes  No

Food collection between teeth  Yes  No

Gums swollen or tender  Yes  No

Mouth breathing  Yes  No

Periodontal treatment  Yes  No

Blisters on lips or mouth  Yes  No

Burning sensation on tongue  Yes  No

Chew on one side of mouth  Yes  No

Loose teeth or broken fillings  Yes  No

Sores or growths in your mouth  Yes  No

# 5 Health History

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date of Last Full Physical \_\_\_\_\_

- |   |  |                       |  |                              |  |
|---|--|-----------------------|--|------------------------------|--|
| AIDS/HIV  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ANEMIA  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head/neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight _____ lbs.            |  |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Height _____ ft. _____ in    |  |
|   |  | Respiratory Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

Do you use tobacco products?

Yes  No If yes, what and how often, how long

Do you use antidepressants or sleeping pills?

Yes  No If yes, list name(s)

Sleep Apnea  Yes  No (C Pap)  Yes  No

Have you had sleep Studies  Yes  No

Do you Snore  Yes  No

Are you on any blood thinners, including aspirin?

Yes mg \_\_\_\_\_  No

Are you currently taking or have you taken any of the following medications?

Alendronate-Fosomax-oral  Yes  No

Clodronate-Ostac, Bonifos-IV and oral  Yes  No

Etidronate-Didronel—IV and oral  Yes  No

Ibandronate-Boniva-oral  Yes  No

Pamidronate-Aredia—IV  Yes  No

Risedronate-Actonel--oral  Yes  No

Tiludronate-Skelid—oral  Yes  No

Zoledronic acid-Zometa—IV  Yes  No

**WOMEN:**

Are you pregnant?

Yes  No If yes when is your due date? \_\_\_\_\_

Taking birth control pills?  Yes  No

Are you taking hormones?  Yes  No

MEDICATIONS	ALLERGIES												
<p>List any medications you are currently taking and the correlating diagnosis:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Vitamins/Minerals <input type="checkbox"/> Herbs</p> <p>Pharmacy Name _____</p> <p>Phone (_____) _____</p>	<table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Local Anesthetic</td> </tr> <tr> <td><input type="checkbox"/> Barbiturates (sleeping pills)</td> <td><input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Sulfa</td> </tr> <tr> <td><input type="checkbox"/> Iodine</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Latex</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> None</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____	<input type="checkbox"/> Latex	_____	<input type="checkbox"/> None	_____
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<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____												
<input type="checkbox"/> Latex	_____												
<input type="checkbox"/> None	_____												

# 6

## CONSENT AND RELEASES

Please **INITIAL** and **SIGN** below.

\_\_\_\_\_ I hereby authorize Dr. Stephen E. Burch and/or his staff to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures, and demonstrations by Dr. Burch and/or his staff.

\_\_\_\_\_ I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. Burch and/or his staff for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand I will receive no further financial compensation for the use, at anytime in the future, of my testimonials, photos, slides, or videos by Dr. Burch and his staff.

\_\_\_\_\_ I hereby give a limited duration of health care power of attorney to (name) \_\_\_\_\_ of (address) \_\_\_\_\_ and (phone) \_\_\_\_\_ my (relationship) \_\_\_\_\_ and by so doing, I hereby give my permission and consent for them to make treatment decision(s), including surgery and medication, on my behalf during my sedation visit(s). I hereby ratify and confirm all that my attorney shall do or cause to be done by virtue of this health care power of attorney and the rights and powers granted herein. Upon conclusion of my sedation treatment with Dr. Burch then this health care power of attorney shall be considered revoked.

\_\_\_\_\_ I understand that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable before the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

\_\_\_\_\_ Pursuant to Virginia Law 32.1-45.1 – Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

\_\_\_\_\_ You must provide us with **48 business hours** advance notice for any cancellations of any of your appointments in order to avoid the imposition of cancellation fees, which are determined by the length and type of service being rendered at the scheduled visit. Such cancellation fees are **non-refundable**.

\_\_\_\_\_ I have read and understood this entire agreement before signing here below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice, and I received a copy of this agreement simultaneously upon my endorsing it.

**\*\*\*\*\*DO NOT SIGN UNLESS YOU'VE READ AND UNDERSTOOD\*\*\*\*\***

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_



# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_

SSN: \_\_\_\_\_

## SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Joey Burch  
Telephone: (703) 827-9250  
Fax: (703) 827-9256  
E-mail: sedationdentist@aol.com  
Address: 8270 Greensboro Dr. # 101, McLean, VA 22102

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03. And will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective on all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provided to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provides performance conducting training programs, accreditation certification licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except to those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member or your personal representative or another person responsible for your care of your location your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up, filled prescriptions medical supplies, x-rays or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstance.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages postcards or letters).



## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions you may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time.

You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$5.00 for each page per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you if you request an alternative format we will charge a cost based fee for providing your health information in that format if you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment payment healthcare operations and certain other activities for the last 6 years but not before April 14 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost based fee for responding to these additional request.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations.( You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended) we may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. department of Health and Human Services.

Contact Officer:       Joey Burch  
Telephone:             (703) 827-9250  
Fax:                     (703) 827-9256  
E-mail :                 sedationdentist@aol.com  
Address:                8270 Greensboro Dr. # 101, McLean, VA 22102

## BROKEN APPOINTMENT FEES

It has come to our attention as all our lives become more taxed by our stressful lifestyles, broken appointments have been increasing. This unfortunately has concerned us simply because we have patients who would love to be seen sooner for their visits, and cannot be offered that opportunity.

We have put a new system in for confirmation of our appointments to be of further service to our patients. It is an automated system that sends you a text or email message that goes out 2 weeks, 2 days, and one hour prior to your appointment. It will continue to cycle through the system unless you **RESPOND** to the system and call and confirm a text message, or hit the **CONFIRM BUTTON** on your email that will notify us that you will be here at your appointed time.

Due to the nature of our practice, we require a minimum of 4 business Days for General Sedation appointments and a minimum of 48 BUSINESS HOURS for all other cancellations to be considered a non charged transaction.

<b>Type of Appointment</b>	<b>Broken Appointment Fee</b>
Consultation	\$63
New Patient Appointment	\$298
Hygiene Appointment:	
Recare	\$100
Root Planning/Power Bleaching	\$200
Triazolam Sedation Doctor Visit	\$500 per hour or fraction
General Sedation Doctor Visit	\$1000 per hour or fraction
Non-Sedation Doctor Visit	\$100-\$1000 per hour or fraction

We regret the need for this, and we apologize in advance for implementing such a system. This way, we can continue to be of the utmost service to all of our patients and staff.

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Witness Signature and Date

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Patient/Guardian Signature and Date