Kodiak Island Family Dentistry

Appointment and Financial Policy

We would like to welcome you to our practice. We are committed to providing you with the best possible dental care. We hope you'll come to enjoy your visits with us.

We make every effort to confirm your scheduled appointments with us. You will receive a call, text or email to confirm your scheduled appointment one to two days prior to your appointment with us. A 24 hour notice of cancellation is required, otherwise your appointment is considered broken. Three broken appointments will result in a $50 charge to set another appointment. If broken appointments persist, our dental/patient relationship will be terminated. Please be courteous regarding this matter as we are hoping to develop a long term relationship with you and your family. Also, please arrive on time for your scheduled appointments. In fairness to our appointed patients, we may reschedule late arrivals. With the same courtesy, we will notify you if we are running late.

Payment is expected at the time of service unless prior financial arrangements have been made. If you have insurance, we expect your copayment and any deductible at the time of service. We will file your insurance as a courtesy to you. If requested we are able to send out a monthly statement of remaining yearly benefits. Please be aware your insurance is a contract between you, your employer, and your insurance company. We are not a party to the contract. We will not become involved in disputes between you and your insurance company regarding deductibles, copayments, or covered charges. We will do all that is in our power to help you get payment for services rendered. Ultimately, it is your responsibility to know your insurance coverage. If insurance has denied any services the entire bill is your responsibility.

Service fee for all return checks are $50.00

I have read the above policy and understand my responsibilities

Signature _____ Date _____

General Consent for Dental Treatment

I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that all treatment and procedures have a risk or separation or breakage of dental instruments which may become logged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact my dentist as soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurances as to the outcome or results of treatment or surgery.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications, and I promise to use that right to its fullest extent if for any reason I feel I am not fully informed about procedures, the risks of the procedures, and the alternative to the procedure.

Name of family members also covered by this:

Signature _____ Date _____

Notice of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under Health Insurance Portability and Accountability Act of 1996 (HIPAA). I do understand that his information can and will be used to provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly, obtain payment from third-party payer for my health care services and conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental providers "Notice of Privacy Practice" containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such "Notice of Privacy Practices" and that I may contact this office at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not requite to agree to my requested restrictions, but if you do agree then you are bond to abide by such restrictions.

Signature _____ Date _____

By signing this, I understand that I am giving my consent and authorization for Kodiak Island Family Dentistry to release any information to myself or a family member regarding myself or anyone listed below. I understand that at any moment I can inform the practice of changes in whom I allow to disclose this information.

Patient Name(s): _____

Relationship to Patient: _____

Information can also be disclosed to: _____

Signature _____ Date _____

I hereby authorize Kodiak Island Family Dentistry to publish photographs taken of myself and members of my family, for use in Kodiak Island Family Dentistry's print and online marketing materials, as well as other Company publications. Further consent will be requested at the time, before doing so. (Examples: cavity free wall, Facebook posts, website)

Signature _____ Date _____

Dental Record Request Form

I authorize _____ to send my records to the clinic/office of Kodiak Island Family Dentistry. This will also include any family members listed below. Please email records to kodiakislandfamilydentistry@gmail.com

Patient Name(s)	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature _____ Date _____

Thank you for your prompt attention