Adirondack Dental Group

Disclosure for Treatment, Payment and Operations

At Adirondack Dental Group, we believe that you deserve the best care.

Please read carefully and initial each paragraph:

_____* Insurance is a contract between you and the insurance company. We will work with your insurance to maximize your benefits; however you are responsible for the timely payment on your account. I understand that failure to keep my account current may result in being unable to receive additional dental services unless on an emergency basis. I also agree to pay collection costs or fees if incurred.

_____* When your appointment is scheduled a unique reservation is made, your materials are ordered and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt and we would appreciate the same courtesy from you. We require 48 hour notice for any appointment changes and without proper notice a fee of $100 may apply. Repeated cancellations or up to three missed appointments will result in dismissal from our practice.

_____* By signing below, I hereby acknowledge that I have been provided with a copy of this offices Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Consent for Treatment

I, _____, consent to and agree to radiographic and clinical examinations along with and diagnosis of treatment.

Authorization for signature on file (Patients with Insurance)

I, _____, hereby authorize Adirondack Dental Group to affix my name to any and all documents as related to any health benefits due me and my dependants through my Employer/Spouse/Retirement/Parent with _____. I hereby authorize payment of my dental benefits otherwise payable to me, directly to the office of Adirondack Dental Group. The “Signature on File” will be valid as long as the insurance is in effect and I am an active patient of record. A photocopy of this document may act as an original