Welcome to our office:

We highly suggest you read the following *before* signing as it outlines our office policies.

ALL PAYMENT IS DUE AT THE TIME OF SERVICE. Our office will file your primary insurance as a courtesy to you, but it is customary for your portion to be due the date services are rendered. For the safety of our Doctors, staff, and patients we have implemented greater standards of Personal Protective Equipment and effective immediately a **Personal Protective Equipment (PPE) fee of $10** will be added to all dental appointments. Payment plans are available through Care Credit and we accept cash, check, Visa, Master Card, and Discover.

A $75 FEE WILL BE CHARGED FOR ANY BROKEN APPOINTMENTS SCHEDULED MONDAY-FRIDAY WITH LESS THAN 48 HOURS NOTICE. ANY BROKEN APPOINTMENT SCHEDULED ON A SATURDAY WILL RESULT IN A $200 FEE WITH LESS THAN 48 HOURS NOTICE. Please note, failure to take needed medications before dental appointments or not having payment at time of service will result in the fee of our Broken Appointments.

Our practice believes in the importance of quality dental care, and we strive to provide the best dental treatment possible. Also, we understand the financial limitations that influence your choice of care. We want to assure you of a flexible approach to financing.

Please, remember, however that **you are responsible for the portion of your treatment not covered by your insurance**. Our insurance department verifies insurance as a courtesy for our patients, but **our office cannot guarantee payment from your insurance**. We do highly suggest patients to personally contact their own insurance carriers to verify coverage. We, to, must balance our finances, thus why we ask you to pay your portion at the time of treatment. For your knowledge, **our four locations have separate statements and accounting as they are four separate locations. You are responsible for making payments to each individual office if seen at multiple locations.**

Please note, accounts 90 days past due will be charged a $25 late fee & interest. If your account balance goes into collections, we will add 33% to the account.

A SERVICE CHARGE OF $25 IS APPLIED FOR ANY RETURNED CHECKS.

We hope that you find this information useful. Rest assured that we are here to help make quality dental care obtainable for all. We look forward to working with you to achieve excellent dental health.

Thank you for choosing our office!

-Lakemoor Dental

______________________________________ DATE: _______________

(PATIENT NAME PRINTED)

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(PATIENT/RESPONSIBLE PARTY SIGNATURE)

HIPAA Compliance Patient Consent Form

Our notice of Privacy provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or send a text to confirm appointments? YES NO

May we leave a message on your answering machine at home or on you cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ______________________________________

(PRINT NAME PLEASE)

Signature:____ Date:________________

COVID-19 CONSENT

Lakemoor Dental has made the decision to cancel all dental procedures until further notice other than procedures we deem as a dental emergency.

You are receiving dental care during the events of a COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of Dentists, other patients, or staff. We are taking the necessary precautions to limit the spread of disease, yet there is a possibility of transmission during this time.

Have you been traveling in the last 14 days?	YES	NO
Have you been experiencing any flu like symptoms? (cough, fever, headache, etc.)	YES	NO
Have you been in contact with anyone with COVID-19?	YES	NO

If you experience any signs or symptoms of COVID-19 within the next 14 days, please contact our office immediately.

By signing you are authorizing that you understand the risks involved and are accepting needed treatment and if you experience any COVID-19 symptoms after your appointment you will contact our office immediately.

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(PATIENTS NAME)

____ __________________

(PATIENT/GUARDIAN SIGNATURE) (DATE)