CONFIDENTIAL

Patient Name: ______________________________________

DOB: _____________ Chart #: _____________

Reservation Information

Please Initial.

_______I grant permission to Dr. Basta, and/or assignees to telephone me at home, on my cell phone, at my workplace or via email to discuss matters related to my account or dental treatment.

_______I authorize Dr. Basta and/or assignees to release financial information, treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information.

_______I authorize Dr. Basta and/or assignees to obtain any medical information from my physician or other treating doctors or dentists to aide in providing dental treatment.

_______This office makes every possible effort to get each patient in to see Dr. Basta and/or her associates in a timely manner. Therefore we appreciate everyone's respect of the schedule by prompt arrival for reserved times.

_______This practice is dedicated to quality care and exceptional service. The importance of time is respected and efforts are made to schedule appointments that accommodate the busy scheduling needs of all. In return, this practice asks that everyone make every effort to keep reserved dental appointments. If you find that you must change your appointment, a minimum of 48-hours notice is required. A $250.00 charge will be applied for broken or missed appointments without advanced notification. Thank you for your cooperation.

Financial Arrangements

Please Initial.

_______Payment is due at the time of service. As a condition of treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

_______Estimated fees are extended for a period of Three (3) months from the date of the patient's examination. As a courtesy to all patients, the use of an outside billing service is offered, which provides a wide variety of no interest and interest-deferred payment options as well as long term payment plans.

_______Due to the complexity of insurance contracts, estimated amount(s) is/are not a guarantee of insurance payment or patient payment. Insurance benefits may be subject, but not limited, to eligibility, plan maximums and limitations, and insurance fee schedules. Any account balances not paid by insurance company within forty-five (45) days will become my responsibility. If not paid by the statement due date, account balances are subject to an 18% annual service charge (1 ½% monthly).

_______There is a $25.00 service charge for any returned checks.

_______Copies of x-rays, panoramic x-rays and charts are available for a nominal fee. Request must be in writing and signed by the responsible party. Please allow 7-10 business days to process all requests.

_______Patient, or financially responsible person(s), agrees to be responsible for the remaining balance plus attorney fees, court costs and collection agency fees. In addition to these named fees, a collection charge of up to 50% of any unpaid balance may also be added.

_______This agreement supersedes all prior agreements as well as any mediation or mediation/arbitration agreements signed previously relating to financial agreements or quality care, and as a result are null and void.

Thank you for reviewing this important information concerning our business procedures. Our dental team is available to answer any questions about your account, scheduling a reservation or just to chat. We will do whatever we can to make your visits with us exceptional!

I have thoroughly read, completely understand, and agree to cooperate with and abide by the procedures outlines above. I acknowledge that a copy of the "Notice of Privacy Practices" has been given to me.

______________________________________ ________________________

Signature of Patient, Parent, or Legal Guardian Date