Tim J. Patel, D.D.S.
Family & Cosmetic Dentistry

Missed Appointment Policy

We strive to provide our patients with the most efficient dental care possible. However, we cannot do so unless everyone arrives promptly for his or her appointment. Consequently, we must have a minimum of 24 hours notice for any appointment change. We have implemented this policy in order to be fair to all patients and allow efficient care for everyone. The missed appointment fee is $40 and will ***not*** be waived under any circumstances! Furthermore, it is not acceptable to unilaterally decide that if you had to wait to be seen by the doctor, you do not have to pay this fee on a subsequent missed appointment. If you have three missed appointments in a row, you will be dismissed from our practice. Due to the nature of our business, it is near impossible for physicians and dentists to gauge actual waiting time for a patient. If you decide to not pay the missed appointment fee, we will pursue full payment thru an independent collection agency. This fee covers less than 25% of our actual out-of-pocket cost of a broken appointment, please be considerate! Thank you for your cooperation.

I acknowledge this 24-hour policy and will abide by it

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Payment For Services Rendered Policy

Due to multiple insurance carriers, we cannot definitively give you a pre treatment estimate that would be accurate based on all of the exclusions and limitations for each and every insurance plan. We will provide you with a pre treatment estimate based on our full fee for the services to be rendered for you. This amount may not necessarily indicate your portion of payment as some plans require your portion of payment as much as 50% of our usual and customary fee for service. You can follow up with your insurance carrier as to the coverage that will be owed based on your annual maximum and any deductible payments. By signing this statement, you are acknowledging that we will submit an insurance claim to your carrier on your behalf; however, the ultimate financial burden will be your responsibility for the contracted agreed amount of payment by your insurance carrier. If collection of payment is not made in a reasonably timely manner, we will pursue full payment through an independent collection agency and you will be dismissed from the practice. Thank you for your cooperation.

I acknowledge this payment for services rendered policy and will abide by it.

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General Informed Consent

Upon explanation by the doctor of the necessary treatment to be rendered, I hereby authorize the performance of dental services. I have been informed of all risks, benefits and alternatives to the treatment and understand the consequences of not having treatment done such as loss of one, some or all of the teeth and progression of periodontal disease. I authorize the administration of any anesthetic agents and radiographs (xrays) that the doctor deems necessary in order to successfully complete my treatment. I have filled out the medical history questioaire to the best of my knowledge and I am aware that anesthetic agents can sometime affect me adversely and if this situation arises the doctor will treat the condition accordingly. I understand that dentistry is not exacting and there are no guarantees however if the treatment has been rendered in a clinically acceptable manner and if I maintain the dental work with adequate home care it will last for a long time.

I acknowledge the general risks, benefits and alternatives associated with my treatment and allow the dentist to perform treatment upon me or my child.

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INFORMED CONSENT

Examination/Diagnosis/Treatment Planning:

Dentistry is a combination of the art and science of restoring and treating conditions pertaining to the teeth and oral cavity. Prior to examination, radiographs and study models may be required, which will aid the dentist in formulating a comprehensive treatment plan. Upon examination, the dentist will perform a comprehensive analysis of the following: overview of the patient's medical history and dental history, assessment of the TMJ (temporomandibular joint) for function and dysfunction, soft tissue exam to rule out neoplastic disease (oral cancer), assessment of the occlusion (how the upper and lower teeth come together), assessment of the radiographs and study models, if required, and a thorough clinical examination to rule out dental caries, periodontal disease, and any malformations or abnormalities, if present. Upon completion of the examination, the dentist will formulate an ideal and alternative treatment plans based on several factors. This treatment plan will then be discussed with the patient or parent of the patient if the patient is a minor, as well as possible risks during and after treatment, and the consequences of not performing the recommended partial or complete treatment at all. Benefits of performing the treatment and the overall outcome, as well as any alternatives to the proposed treatment, will then be discussed. (Initials_____)

Changes in Treatment Plan:

I understand that during treatment, it may become necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination and/or treatment. The most common being a direct or indirect pulp cap (placement of a liner/base underneath a permanent restorative material in order to alleviate sensitivity), root canal therapy, crown lengthening therapy or extraction following routine restorative procedures. I understand that if changes are required, the doctor will notify me verbally and discuss the treatment and all risks, benefits and alternatives associated with the treatment. I give my permission to the dentist to make any and all changes deemed necessary within his best clinical judgment. (Initials_____)

Drugs and Medications:

I understand that the use of local anesthetic agents may cause the following: temporary or permanent paresthesias/anesthesias (altered sensations or complete loss of sensations to the localized and peripheral areas, which are undergoing treatment. In rare instances, this can be permanent), neuromas (injury to the nerve which may result in transient pain which in rare instances can be permanent), allergic type or toxic type reactions, or contraindications with other medications or health conditions. I understand that analgesics (pain medications) may be prescribed and may cause drowsiness, nausea, vomiting, allergy, toxicity, changes in heart rate/function and respiratory rate/function. I understand that antibiotics (medications used to subside and eliminate infections) may be prescribed and may cause allergies, nausea, vomiting, diarrhea, constipation and inactivation of oral contraceptives. If an emergency event should occur prior to, during, or after delivery of anesthetic agents, analgesics, antibiotics, the dentist will treat the condition with the necessary drugs to combat the problem or refer to a physician or emergency room. (Initials_____)

Patient/Guardian Signature_____

Staff/Witness Signature_____

Date_____

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