



## **MEDICAL CONSENT**

By signing below, I agree that I understand the medical information given is necessary to provide me with dental care in a safe and efficient manner. I will answer all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

## **CONSENT FOR TREATMENT**

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. These models and photographs may be used as necessary for teaching aids as well as promotion of the practice by Kelly Blair DDS or Jerry Scott DDS.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

## **FINANCIAL POLICY**

- We will be happy to help you verify and maximize any insurance you have. We must emphasize in our practice, our relationship is with you, not your insurance company.
- I understand that any insurance reimbursements may come directly to me for services rendered, and that claims may be submitted on my behalf. I understand that ultimately, insurance is the patient responsibility.
- I agree to be responsible for payment of ALL services rendered on my behalf or my dependents on or before services are provided. I understand that a deposit may be due to reserve my appointments, and the balance will be due at the time of service. I also understand a check of my credit history may be made if I request a payment plan.

## **CANCELLATION POLICY**

- Please arrive at least ten minutes before your scheduled appointment time in order to ensure a complete appointment.
- You may cancel your appointment without charge with a minimum of 24 hours' notice prior to your scheduled appointment time.
- If we have asked your spouse to accompany you and they are unable to make it without rescheduling in advance, you may be charged a cancellation fee and rescheduled to a different day.
- Same day cancellations will be charged a minimum of \$75 and up to 50% of the scheduled treatment price.
- If you do not call to cancel your appointment or do not show up for your scheduled appointment, you may be charged full price for the scheduled treatment.

Thank you.

*Dr. Blair & Team*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_