Valued Patient Agreement

the Art of Dentistry and Spa

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Welcome to our office and thank you for selecting us for your dental care. Your needs are our highest priority. Our exceptional and highly trained team is committed to the highest standards of quality to provide you with very best dental treatment. In our office we have created a comforting and relaxing environment where you will feel cared for with personal attention and genuine compassion. This agreement outlines some of our office procedures and provides you with an understanding of what we can expect from each other as we move forward with our relationship.

Appointments

Our patients come first. Each appointment is reserved especially for you. We will see you on time and we ask that you be on time for your visit. Failure to make a reserved appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make a reserved appointment (except in cases of emergency) you are expected to call 48 hours prior to that appointment to notify us. There is a $100 fee per scheduled hour for all “failure to show” appointments. After three (3) missed appointments, the practice may, at its discretion, choose to discontinue your care.

Payments

You or your guarantor is responsible for any co-payments in full at the time treatment is provided. Any one of our administrative team members will be happy to discuss our available financial arrangements options for payment of procedures. Please know, any returned checks are subject to a $35.00 fee.

Dental Insurance

Treatment recommendations are based on your health, not your insurance. It is your responsibility to know what your insurance benefits are. Your insurance benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not consider “covered expenses”. Be aware, we are out of network with all carriers except for Delta Dental Premier. It is important to remember that insurance companies are not concerned about your health and wellbeing- WE ARE. We will provide you with an estimate of insurance benefits, however, it is important to be aware that these estimates of benefits often change and at times are not accurate. You authorize the release of any dental information necessary to process your dental insurance claims. This authorization remains valid until you give written notice that it is explicitly revoked. You are fully responsible for any charges incurred for treatment provided to you.

Dental Insurance Payments

As a courtesy, The Art of Dentistry and Spa will prepare your insurance forms, assist in making collections from the insurance companies and will credit any collections to your account. By signing this agreement, you agree to authorize and request your insurance company to pay directly to the doctor insurance benefit otherwise payable to you. You understand that your insurance carrier may pay less than the actual bill for the service.
You also agree to assign, transfer and set over to The Art of Dentistry LLC, all your rights, title and interest to any dental reimbursement benefits under your insurance carrier for dental services provided by our office. If your dental insurance carrier should send you the payment for the dental services that we provide for you, then you agree to turn over to us that payment within 10 days after you have received such payment.

Collections and Credit

You agree that if a lawsuit or action is brought to collect this account or any portion of it, that you agree to pay a onetime finance charge of $50.00 plus the costs of collection, including but not limited to, taxable and nontaxable costs and disbursements provided by statute as well as attorneys' fees amounting to one-third of the total outstanding balance. You also agree to pay interest at the rate of 1.5% per month (18% per year) on the total balance owed after 30 days from the date that you are first billed until the outstanding balance is paid in full. You also agree that if The Art of Dentistry, L.L.C. extends credit to you or if your treatment balance is substantial, that The Art of Dentistry, L.L.C. may, at its discretion, request a credit report on you. If The Art of Dentistry, L.L.C. does not grant credit to you based on a credit report, you will be told why credit has been denied and you will be supplied with the name and address of the credit agency from which the credit report was received. This will give you the opportunity to correct any errors or disputes on your credit report if any should exist.

Minors

If you are under the age of 18 at the time services are provided, your parent or legal guardian's signature below constitutes an agreement and guarantee by your parent or legal guardian that they and you are responsible for paying any all fees. Your parent or legal guardian's signature also is an acknowledgement that the services provided are "necessary" dental expenses.

Consent to Treatment

You consent to be treated and represent that all the foregoing information is true and correct to the best of your knowledge, including the information provided on the Patient Information Form. If any of the above information changes you will immediately notify The Art of Dentistry and Spa, L.L.C.

I hereby give The Art of Dentistry, LLC, Dr.'s Berry, Chencharik, Roland, Blick, George, Burack and staff permission to transmit my radiographs and other pertinent information related to my treatment at my request or their necessity.
A photocopy of this agreement shall be considered as effective and valid as the original.

Consent for Social Media

I give my permission for The Art of Dentistry and Spa and their respective dentists to use pictures of my smile, both before and after, in the capacity of case presentation. I understand that my photos, both before and after, may be used for social media posts (Instagram and Facebook), company website gallery, as well as in-office photography.
I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential unless you allow otherwise.

Print Patient Name ______________________________

Signature of Patient ______________________________ **Date** ________________

Print Name of Responsible Party______________________________ **Relationship** ________________

Signature of Responsible Party______________________________ **Relationship** ________________