Simply Dental

4460 Atlanta Hwy
Loganville, GA 30052
770-554-3700

Consent for Services

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary (including nitrous oxide). I fully understand that using such anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand and agree that I am responsible for any portion of my bill that my insurance company does not pay within sixty days of claim submission. I understand payment is due at the time of service. In the event that payments are not received by agreed upon dates, I understand that a late charge of 1.5% (18%) may be added to my account.

If this account must be turned over to collections, then you would be responsible for all collection fees charged by the agency.

_____ _____ _____

Signature of Patient, or Guardian Date Relation to Patient

Acknowledgement of Receipt of Privacy Practices and HIPPA Statement.

I have received a copy of the Notice of Privacy Practices and a copy of the HIPPA statement for the above named practice.

_____ _____ _____

Signature of Patient, or Guardian Date Relation to Patient

Insurance Authorization

I authorize release of information to all my insurance carriers

I understand that I am responsible for treatment not paid by my insurance within 60 days after claim submission.

I authorize payment directly to my doctor

I authorize my doctor to act as my agent in helping me obtain payment from my insurance

We reserve your appointment time on our schedule. We ask your consideration in keeping your Appointments. If you must miss you're appointment, please call 24 in advance so that we may be able to fill that time slot with another patient. If you miss or cancel 2 appointments without giving proper notice you will be given a referral to another office and will be dismissed from our practice.

_____	_____	_____
Signature of Patient, or Guardian	Date	Relation to Patient