GENERAL HEALTH INFORMATION

Magic Touch DENTAL

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____

DENTAL HISTORY

1. Reason for a Visit/ Main Concern? Check-up ☐ Cleaning ☐ Toothache ☐ Other _____
2. Are there other conditions of which we should be aware? YES ☐ NO ☐ If yes, please specify: _____

_____

3. When did you last visit a dentist? _____ 4. What treatment was perform? _____
5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____
7. Did you have a cleaning? YES ☐ NO ☐ 8. Have you had gum (periodontal) treatment? YES ☐ NO ☐
9. Have you had prolonged bleeding after an extraction? YES ☐ NO ☐ If yes, please specify: _____
10. Have you had any problem with past dental treatment? YES ☐ NO ☐ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near you ear such as clicking, popping, pain or lock open?
    YES ☐ NO ☐ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ?
    YES ☐ NO ☐ If yes, please specify: _____
13. Do your gums bleed easily? YES ☐ NO ☐ 14. Do you feel you have bad breath? YES ☐ NO ☐
15. Are your teeth sensitive to hot or cold? YES ☐ NO ☐ 16. Would you like your teeth whiter? YES ☐ NO ☐
17. Are you happy with your smile? YES ☐ NO ☐ If yes, please specify: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ☐ NO ☐ If yes, please specify: _____
   Doctor Name _____ Doctor Phone: ( ) _____ -- _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ☐ NO ☐ If yes, please specify:

   _____
4. (Women) Are you pregnant now? YES ☐ NO ☐ If yes, how many months? _____ Are you nursing? YES ☐ NO ☐
5. Are there any other health problems of which we should be advised? YES ☐ NO ☐ If yes, please specify: _____

   _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comment	Please check "YES" or "NO"			Doctor Comment
ARTIFICIAL HEART VALVE	YES ☐	NO ☐		HEPATITIS	YES ☐	NO ☐	
AIDS/HIV+	YES ☐	NO ☐		HIGH BL. PRESSURE	YES ☐	NO ☐	
ANEMIA	YES ☐	NO ☐		JAUNDICE	YES ☐	NO ☐	
ANGINA	YES ☐	NO ☐		JOINT REPLECEMENT	YES ☐	NO ☐	
ARTHRITIS	YES ☐	NO ☐		KIDNEY DISEASE	YES ☐	NO ☐	
ASTHMA	YES ☐	NO ☐		LATEX ALLERGY	YES ☐	NO ☐	
BISPHOSPHONATE THERAPY	YES ☐	NO ☐		LIVER PROBLEMS	YES ☐	NO ☐	
BLEEDING PROBLEMS	YES ☐	NO ☐		LOW BL. PRESSURE	YES ☐	NO ☐	
CANCER	YES ☐	NO ☐		LUNG DISEASE	YES ☐	NO ☐	
CHEM/RAD THERAPY	YES ☐	NO ☐		PACEMAKER	YES ☐	NO ☐	
COSMETIC SURGERY	YES ☐	NO ☐		PSYCHIATRIC CARE	YES ☐	NO ☐	
DIABETES	YES ☐	NO ☐		RHEUMATIC FEVER	YES ☐	NO ☐	
DIZZY SPELL	YES ☐	NO ☐		SINUS TROUBLE	YES ☐	NO ☐	
DRUG ADDICTION	YES ☐	NO ☐		SLEEP APNEA	YES ☐	NO ☐	
EMPHYSEMA	YES ☐	NO ☐		TOBACCO	YES ☐	NO ☐	
EPILEPSY	YES ☐	NO ☐		STROKE	YES ☐	NO ☐	
FAINTING	YES ☐	NO ☐		THYROID PROBLEMS	YES ☐	NO ☐	
GLAUCOMA	YES ☐	NO ☐		TMD OR TMJ	YES ☐	NO ☐	
HEART ATTACK/SURGERY	YES ☐	NO ☐		TUBERCULOSIS	YES ☐	NO ☐	
HEART MURMUR/PROBLEMS	YES ☐	NO ☐		VENEREAL DISEASE	YES ☐	NO ☐	

To the best of my knowledge, I have answer every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent/Guardian if Patient is a Minor)

Doctor's signature _____ Date _____

PATIENT INFORMATION

Magic Touch DENTAL

Patient

Name_____
Last First
Address_____APT #_____
City_____ZIP_____
How long at this address? _____
Home phone ( )_____--_____
Cell/Pager ( )_____--_____
E-mail_____
Social Security _____
Driver License# _____
Age_____Birth Date_____

RESPONSIBLE PARTY

Name_____
Last First
Address_____APT #_____
City_____ZIP_____
How long at this address? _____
Home phone ( )_____--_____
Cell/Pager ( )_____--_____
Social Security_____
Relationship to Patient _____
Age_____Birth Date_____

EMPLOYMENT

Occupation_____
Employer_____
How long? _____
Business address_____
City_____ZIP_____
Business Phone ( )_____--_____EXT# _____

REFERENCES

Name_____
Last First
Phone ( )_____--_____

Name_____
Last First
Phone ( )_____--_____

Spouse's Name_____
Last First
Spouse's Phone ( )_____--_____

PERSON TO CONTACT FOR EMERGENCY

_____
Last First
Phone ( )_____--_____

GETTING TO KNOW YOU

Do you have any family who may need dental care?
If so, please list the name & relationship (son, daughter, husband, ect.)
1:_____ 2: _____
3:_____ 4: _____

How did you hear about our office? (Circle one)

Family-Friend	Insurance plan
Television	Newspaper
Billboard	Radio
Yellow Pages	Flyer-Coupon
Direct Mail- Postcard	Office sign
Internet-Website	Office transfer

I want information in Spanish: YES_____NO_____

INSURANCE / DENTAL PLAN

Primary Insurance: PPO MEDICAID MEDICARE
Plan Name _____
Address_____
City, State, Zip _____
Insurance / Plan Phone#_____
Employer_____
Group#_____Plan #_____
Insured's Name _____
Insured's Social Security _____
Secondary Insurance: PPO MEDICAID MEDICARE
Plan Name _____
Address_____
City, State, Zip _____
Insurance / Plan Phone#_____
Employer_____
Group#_____Plan #_____
Insured's Name _____
Insured's Social Security _____

- **I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.**
- **By signing below, I authorized that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.**
- **I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I authorize release of any information relating to any dental claims.**
- **I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.**

_____
Signature of Responsibility Party DATE
(Parent/Guardian if Patient is a Minor

Magic Touch
DENTAL

Informed Consent
General Dentistry

All patients complete 1 thru 5 below, and 6 thru 13 as needed.

1. EXAMINATIONS AND X-RAY

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials_____)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction. I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effect and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

(Initials_____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make and/all changes and additions as necessary.

(Initials_____)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials_____)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials_____)

6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials_____)

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____and any others necessary for reason in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissues (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly If it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

8. DENTURES-COMPLETE OR PARTIICAL

I realize that full or partial dentures are artificial or plastic, metal, and/or porcelain. I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that the appliances are not "permanent." The problems of wearing those appliances have been explains to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit and size, placement, and color will be the "teeth in wax" try-in visit. Immediate dentures (placement of a denture immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges. I understand that I will have two free adjustments within one month after my delivery of denture/partial. Additional adjustment will be my responsibility.

(Initials_____)

9. CROWNS, BRIDGES, VENEERS, AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth, I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials_____)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials_____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials_____)

10. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth that complications can occur for the treatment and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canal fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is myresponsibility.

(Initials_____)

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal diseases may have a future adverse effect in the long-term success of dental restoration work.

(Initials_____)

12. IMPLANTS

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting there artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves if the face and tissues if the oral cavity, and this numbness may be of a temporary or rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have periodic examinations and cleaning. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials_____)

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shade on the dental shade guide. Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity if the teeth and/or gum inflammation, which may subside when treatment is discontinue. The Dentist may prescribe fluoride treatment to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advises to consult with their physician before starting treatment.

(Initials_____)

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. There include, but are not limited to, nausea, vomiting, dizziness, and headaches. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials_____)

15. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge the no guarantee or assurance has been made by anyone regarding dental treatment I have request and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return

Signature:_____ **Date:**_____

Doctor: _____ **Date:**_____

(Complete both side)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This Notice of Privacy describes how we may use and disclosed your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also described your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We are required to abide by the terms of this Notice of Privacy Practices. We will not use or shared your information other than as described here unless you can tell us in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time, as well as for any information we receive in the future. Upon your request, we will provide you with any requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use or disclose your health information to obtain payment or services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operation include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing actives.

Your Authorization and Limitations: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restriction on disclosure of PHI (Personal Health Information), or alternative means of communication (e.g. home or business phone) to ensure privacy. We are not required to agree to all request, and we may say "no" if it is not reasonable or would affect your care. If you pay for a service or item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your insurer. We will say "yes" unless a law requires us to share that information.

Marketing Health-Related Services: We will not use your health information for marketing communications or sell your health information without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may use or disclose your health information to appropriate when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcard, or letters).

PATIENT RIGHT

Access: You have the right to look at or get electronic or paper copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information. We may say "no" to your request, but we'll tell you in writing.

Accounting: You can request a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosure except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable fee if you ask for another one within 12 months.

Representative: If you have given someone medical power of attorney or someone is your legal guardian, that person can exercise your right and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practice or have questions or concerns, please contact us.

If you are concerned that we may have violated your rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using our EthicsPoint Help line which is (888)366-6034. You also may submit a written complaint to the U.S Department of Health and Human Services upon request.

We support your right to the privacy of your information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PROVACY PRATICES AND CONSTENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____

Print Patient's Name Date

_____ _____

Print Parent or Legal Guardian's Name Date

I,_____, acknowledge that I have received a copy of this
(Signature of Patient or Parent or Legal Guardian)
NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of my personal
(Signature of Patient or Parent or Legal Guardian)
Health information by your office for Treatment, Billing/Payment and Health Operation as outlined in the NOTICE OF PRIVACY PRACTICES

Magic Touch
DENTAL

NOTICE TO INSURANCE PATIENTS

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS

A. The treatment goes over my yearly maximum
B. My insurance company denies any treatment
C. I am not eligible for insurance
D. I prevent or delay payment by not complying with the requests for insurance forms or signatures
E. I do not complete my treatment and it results in non-payment by the insurance company
F. Lab cost are incurred due to missing appointments
G. I received my insurance check and do not send it to your office.

I hereby authorized payment directly to the above named dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorized. I hereby accept the foregoing treatment plan and authorize release of any information relating to this claim.

I have read and understand my obligations in acceptance of my dental insurance as payment.

Patient Signature:_____ Date: _____
(Patient or Responsible Party)

Witness Signature:_____ Date: _____

Magic Touch
DENTAL

Financial Policy

Magic Touch Dental Financial Policy is in place to assure maximum dental care and minimal confusion in the delivery of your treatment.

Below is our Financial Policy that is outlined for your review. You are asked to read, Initial and sign the bottom of this form. If you have any questions concerning any of the below information please bring it to the attention of the Patient Coordinator.

Please initial the following:

A) Magic Touch Dental will obtain an **Estimate of benefits** from your insurance provider for every treatment that is rendered. We are not responsible for any variation in the actual payment or unforeseen policy provisions that may affect payment from your insurance company. If the co-payment from the insurance company exceeds the estimate amount, Magic Touch Dental will credit your account and send the overpayment to you. **ANY AMOUNT NOT PAID BY THE INSURANCE COMPANY WITHIN 45 DAYS IS THE PATIENTS RESPONSIBILITY IN FULL.**

B) **I shall keep my scheduled appointments.** I understand that when I make an appointment, Magic Touch Dental has specifically set that time aside for me. If I don't show up, or cancel at the last minute; that reserve time is lost, where another patient could have been scheduled. I also understand that a **48 hour notice** must be given for any appointment that will not be kept. **Failure to do so will result in a broken appointment fee of $75.**

C) **I understand that a deposit for all major appointments is required.**

D) All co-payments can only be made by cash, money orders, or credit card. No checks.

E) Any payments made by the insurance company that are sent to me or my responsible party **MUST be signed over to Magic Touch Dental** unless payment in full has been previously received by Magic Touch Dental.

F) I have read and understand all of the financial policy provisions outlined above by Magic Touch Dental. Any question I may have has been addressed prior to my signature and I take full financial responsibility for my account and knowledge of my insurance provisions.

G) **I** authorize the Magic Touch Dental staff to call and **leave a detail message, on the phone numbers that I have provided, regarding any appointments I may have as well as any financial agreement** we have made or discussed.

X

Patient/Guardian Signature Date

Política Financiera

Magic Touch Dental Política Financiera está en su lugar para asegurar el máximo cuidado dental y un mínimo de confusión en la entrega de su tratamiento.

A continuación se muestra nuestra Política Financiera que se describe para su revisión. Se le pide que lea, iniciales y firme la parte inferior de este formulario. Si usted tiene alguna pregunta acerca de cualquiera de la siguiente información por favor traiga a la atención de la Coordinadora de Pacientes.

Escriba sus iniciales los siguientes:

A) Magic Touch Dental obtendrá una **Estimación de beneficios** de su compañía de seguros para todos los tratamientos que se representa. No nos hacemos responsables de cualquier variación en el pago efectivo o disposiciones políticas imprevistas que pueden afectar el pago de su compañía de seguros. Si el co - pago de la compañía de seguros supera el importe estimado, Magic Touch Dental le acreditará su cuenta y enviara el pago excesivo a usted. **CUALQUIER CANTIDAD NO PAGADA POR LA ASEGURADORA DENTRO DE 45 DÍAS ES LA RESPONSABILIDAD DE LOS PACIENTES EN SU TOTALIDAD.**

B) **Voy a mantener mis citas programadas.** Entiendo que cuando hago una cita, Magic Touch Dental ha establecido específicamente que reservara tiempo para mí. Si no aparezco, o cancelo en el último minuto, para que el tiempo de reserva se invierta en otro paciente que podría haber sido programado. También entiendo que debo dar un **aviso de 48 horas** para cualquier cita que no se mantendrá. **De lo contrario, dará lugar a una tasa de nombramiento rota de $75.00.**

C) **Entiendo que se requiere un depósito para todas las citas mayores.**

D) Todo el co- pagos sólo pueden realizarse en efectivo, giro postal o tarjeta de crédito. No se aceptan cheques.

E) Cualquier pago realizado por la compañía de seguros que se envían a mí, **deberá ser firmado a Magic Touch Dental** a menos que el pago total se ha recibido previamente por Magic Touch Dental.

F) He leído y entendido todas las disposiciones de política financiera señaladas anteriormente por Magic Touch Dental. Cualquier pregunta que pueda tener se ha abordado antes de mi firma y asumir la responsabilidad financiera por mi cuenta y el conocimiento de mis provisiones de seguros.

G) Yo autorizo al personal de Magic Touch Dental llamar y **dejar un mensaje de detalle, de los números de teléfono que he proporcionado, en relación con citas que pueda tener, así como cualquier acuerdo** financiero que hemos hecho o discutido.

X

Patient/Guardian Signature Date