BURCHWOOD DENTAL

_____ **Patient Authorization Signature:** The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for the benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim. I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____**Patient Consent:** I authorize Dr. Stacie Burch and staff to take all necessary x-ray's, study models, and other diagnostic aids as needed to make a thorough diagnosis. Similarly, I authorize Dr. Stacie Burch to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics (as needed), and I am fully aware that using anesthetic agents involves certain risks.

_____**Minor Children:** Children under the age of 18 years old must be accompanied by a parent or legal guardian to All dental visits, and that parent and /or guardian must remain in the office for the duration of the child's dental visit.

_____**Financial Policy:** Payment is due when services are rendered. Dr. Stacie Burch and staff realize that dental insurance is a confusing and sometimes overwhelming experience for our patients. As a result, we agree to file your insurance as a courtesy to you. I understand that I am responsible for All fees regardless of insurance coverage. I also understand BurchWood Dental attempts to estimate charges covered by insurance; however, adjustments may be necessary and responsibility remains with the patient. After 60 days, you are responsible for any balance on your account not paid by the insurance company for any reason. Should my account become delinquent, I (the patient) will assume all additional collection costs and legal fees.

_____**Broken Appointment Policy:** Dr. Stacie Burch and staff respect our patients and strive to stay on schedule. It is important for our patients to understand that an appointment is a time set aside for you. Due to this, it is important that you give our office ample time if you need to reschedule your appointment. If you must change your appointment, we require at least 24 hour notice to avoid a $25.00 cancellation fee. If 24 hour notice is not given, it will be deemed a broken appointment. After three broken appointments we will no longer be able to make a scheduled appointment for you. However, if you need to be seen for and appointment we will put you on our call list and call you should we have a cancellation.

_____**Cell Phone and Mobile Device Policy:** Due to HIPAA regulations and for patient privacy and safety, cell phones and other mobile devices are not allowed in treatment areas. Please turn off or silence all devices and store them while being treated.

_____**Treatment Area:** Due to HIPAA regulations and for patient and staff safety, only those being treated will be allowed in the treatment area. Parents, a member of the staff will bring you back to the treatment area if needed while we are with your children.

Acknowledgement of Office Policies

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dr. Stacie Burch, DDS, PLLC office policies. I understand that I am responsible for All fees regardless of insurance. My signature below confirms I have read, understand, and agree to comply with this office's policies.

Patient Name (Print): _____ Date: _____

Signature of Patient or Legal Guardian: _____