LUCERO DENTAL GROUP
12833 Harbor Blvd F-3 Garden Grove, Ca 92840
2740 S. Bristol St 206 Santa Ana, Ca 92704

# DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any procedures we may, with your agreement, perform. We want to involve you in all decisions concerning procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like "fillings" can lead to major complications that cannot be foreseen. For example, "Novocain" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to extreme temperatures (hot and cold).

These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems. I have read, understand and consent to dental treatments.

INITIALS: _____DATE:_____

## HIPPA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's HIPPA Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

## PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are required to pay for services as rendered. We accept cash, Visa, MasterCard, American Express and Discover or Debit/ATM cards. We also accept financing through CareCredit.

## OFFICE POLICY

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. **We reserve the right to charge for any appointment(s) broken without a 24 hours notice. The charge will be $50. Checks returned**

**from the bank is subject to a $35 service fee**. Since your insurance company only pays for the service and the reading of the x-rays, **a $30 fee will be charged for copies of x-rays requested by patients**. Accounts delinquent more than 60 days will be sent to our collection agency. We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

**I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT AND FINANCIAL POLICIES**.

Signature: _____Date:_____

# OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

**Cash Patients**

Patients with no insurance are expected to pay in cash, check, credit card or CareCredit the day the service is rendered, unless specific arrangements are made in advance.

**Insurance Patients**

For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 45 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

**Sincerely, Lucero Dental Group**

**I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED FINANCIAL POLICIES.**

_____ Date: _____

Signature of responsible party

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Please print your name