Office, Dental Insurance and Financial Policies

Dear Patient:

Thank you for choosing The Khisti Dental Center for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes, etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family feel welcome to our dental family.

Since we know it is not always possible to pay your dentist bill in full, we would like to explain our financial options. Payments may be made by cash, check, VISA, MasterCard, Discover, or American Express. There will be a $35.00 charge for any returned checks. Please choose the option that works best for you.

- **Dental Insurance- If you have dental insurance, as a courtesy to you, we will file electronically with all the necessary information and submit it to the insurance company. We ask that you pay the estimated expense at the time services are rendered. The co-pay is an estimated amount based on the information that is provided to us. Once we submit the claim, the amount may vary and you will be responsible for the difference.**
- **Monthly Payments- If you need to make long-term payments we can offer financing with Care Credit. You must qualify to use this option.**

FOR SEPARATED OR DIVORCED PARENTS, OUR POLICY IS THAT A PARENT WHO BRINGS THE CHILD TO THE OFFICE FOR TREATMENTS IS RESPONSIBLE FOR PAYMENT OF THE CHARGES.

All patients with an outstanding balance will receive a statement each month. We reserve the right to apply a billing charge of 2% per month (APR 24%) on all accounts 60 days past due.

****We reserve the right to charge for broken appointments which include those broken without 24-hrs. notice, 48-hrs. for sedation cases, and 72-hrs. for appointments scheduled on Mondays. The cost for a broken appointment is $50.00.**

SIGNIFICANT EXPOSURE-Section 32.1-45,1(A) and (B), code of Va. (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given the patient and/or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

I authorize and release information and payment of my dental insurance to the dentist. I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles, or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges that incurred to collect this account) on the principal balance of 18% per annum from date of service.

_____ _____

Signature of patient (or Parent/Guardian if minor) **Date**

Informed Consent of Dental Treatment

Dentistry to be Performed:

I consent to allow the doctor and/or clinical staff to obtain all necessary diagnostic information, such as radiographs (x-rays), as needed in order to reach a diagnosis of my condition. I understand that the doctor will visually examine my mouth and I will be asked to review all benefits, pertinent risks and alternatives to proposed treatment. My financial responsibility will be identified and I acknowledge that it will be my responsibility to pay these fees when treatment is started. My signature on the treatment will be acknowledgement that all this information has been presented to me, that I understand the proposal and that I consent to start treatment as listed.

Please Initial_____

Changes During Treatment:

I understand that during treatment it may be necessary to change or add procedures because of conditions which were not evident during the initial examination. If such change or addition should occur the doctor will discuss the benefits, pertinent risks and alternatives, then ask for my initials or signature and date as consent of the changes prior to continuing.

Please Initial_____

Anesthesia or Medication:

I understand that I may require injections of local anesthesia, the use of nitrous oxide or may be prescribed antibiotics and/or analgesics. These medications can cause unusual or allergic reactions, including, but not limited to: nausea, swelling, pain, itching, tissue irritation, respiratory problems, prolonged muscle soreness, prolonged numbness of the lips or tongue, accidental tongue or lip biting while numb, or drowsiness. If I suffer any of these symptoms I will contact the doctor immediately for evaluation of my symptoms. I do voluntarily assume the possible hazards and risks as mentioned above and any possible side effects not mentioned and do agree to hold harmless The Khisti Dental Center, the doctors and staff.

Please Initial_____

Basic Restorations (Fillings):

I understand that The Khisti Dental Center does not use or offer the silver amalgam material for restorations. I understand that if my insurance carrier provides a lesser alternate benefit for silver amalgam restorations, I will be responsible for the difference between the silver amalgam and the composite resin (white, tooth colored material) restoration fee.

Please Initial_____

Crowns, Bridges, and Cosmetic Procedures:

I understand that I will be wearing a temporary crown, which may come off easily and that I must be careful to ensure that it is kept on until the permanent crown is cemented. I will be shown the final restoration before it is permanently installed. If I wish any changes, I must inform the doctor prior to cementation or give consent for the permanent cementation of the restoration. If I choose porcelain or bonded acrylic restorations, which are subject to chewing force, I understand that the restoration may fracture when I chew or it may prematurely wear down my opposing teeth and that The Khisti Dental Center, will not be responsible for any of these consequences and it will be my responsibility to pay additionally for any rendered subsequent services. I understand that once I have accepted the final restoration, and the doctor has permanently cemented it, any further changes or replacement will be at an additional expense. I understand that the potential complications include, but are not limited to: tooth nerve death which would necessitate root canal treatment or tooth extraction, recession of the gum tissue surrounding the tooth which may create an adverse cosmetic result, and the inability to match the color or shape of the adjacent or opposing natural teeth.

Please Initial_____

Signature of Patient (or Parent/Guardian if minor): _____ Date: _____

Doctor Signature: _____ Date: _____

Witness Signature: _____ Date: _____