Jon Douglas Lesan, DDS, RPh, PA

OFFICE POLICY

Welcome to the dental office of Dr. Lesan. We thank you for choosing our dental office and hope your dental needs are met to the highest expectations. As a patient under Dr. Lesan, we ask that you observe and follow the policies of our office. These policies are put into place for yours and other patient's benefits, and to maintain a steady and efficient flow throughout the dental office. Should you have any questions or concerns please ask any of our front desk personnel, we will try and answer your questions to the best of our knowledge. Thank you.

Please read and initialize each paragraph.

INSURANCES: Our dental office has contracted to participate with the following insurances: **United Healthcare, Delta Dental, Delta Enhanced, Metlife, Cigna and Ameritus**. We file all other insurances as a courtesy to you, and try to work with your insurance to the best of our ability. If we are unable to contact your insurance company or retrieve payment by your insurance company, we may bill the full procedure amount to you, and ask that you contact your insurance company in order to receive payment for the procedure.

_____(initialize)

CO-PAYS/DEDUCTIBLES: ***All co-pays and deductibles are due at the time of service.*** Most insurances have a 20% co-pay for basic procedures such as fillings. However, we do not know the full amount your insurance will pay until the explanation of benefits (EOB) has been received. Any and all remaining balances, after your insurance has paid, will be the sole responsibility of the patient/responsible party. You will receive this note of balance as a statement from our office. If the procedure amount changes during the procedure, you will be notified during the procedure and be asked to pay the difference (or be reimbursed the difference) at the check-out desk. Our office accepts cash, check, MasterCard, Visa, Discover, American Express, and CareCredit.

_____(initialize)

RETURNED CHECKS: There is a $25 return check fee that will be assessed to your account and added to your next statement should your check be returned for insufficient funds. Our office will notify you of the returned check and expect another form of payment for the balance within 7 days. If this balance and $25 return check fee is not paid within 30 days, we will begin legal action by sending your account to the Onslow County Courts under their "Bad Check Program."

_____(initialize)

PARENTAL RESPONSIBILITY OF MINORS: According to North Carolina Law, any child under the age of 18 is considered a minor, unless married or legally emancipated from their parents. A minor may not receive dental work without a parent or an adult supervisor (with written permission from a parent) present in the building. For protection to minors, we will ask to make a copy of a photo ID of the adult supervisor. **ADULT SUPERVISORS WITH WRITTEN PARENTAL PERMISSION ASSUME FINANCIAL RESPONSIBILITY OF ANY PROCEDURES COMPLETED DURING THAT VISIT.**

_____(initialize)

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APPOINTMENT CONFIRMATIONS: As a courtesy, our office will give a 24-48 hour courtesy call, text or email to you to remind you of your appointment. We do reserve the right to double-book your appointment and reappoint with another patient if we do not hear back from you within 24 hours. Please be sure to keep us in mind when you change your home phone, work, or cell phone numbers.

Home Phone: _____ Mobile Phone:_____

Email: _____

We reserve our time, facilities and equipment especially for you so that you may receive quality dental care. To prevent our fees from rising, we politely request at least a 48 hour notice if you are unable to keep your reserved appointment. We also ask a courtesy confirmation back from you in order to keep your appointment.

_____(initialize)

LATE ARRIVALS: We attempt to schedule our patients and maintain a timely and efficient flow of people through the office in order to reduce your wait time in our reception area.. We ask that you arrive 10-15 minutes early prior to your appointment to fill out any new paperwork. Should you arrive over 15 minutes late, we reserve the right to reschedule your appointment. However, if we are late in getting you back due to another patient being late, we do allow you to reschedule your appointment.

_____(initialize)

TREATMENT PLANS: Our office is responsible for diagnosing and recommending a treatment according to the conditions seen within the patient's oral cavity. The recommended treatment is documented on a "TREATMENT PLAN" and presented to the patient/responsible party with its full options available. These options could include a referral to a specialist for further evaluation and care. By signing the treatment plan, you do not commit to the treatment, but agree and witness that a treatment plan was given to you. Once a treatment plan has been made, it is the patient's responsibility to make and attend their designated appointments.

_____(initialize)

CONDITION TO COMMIT TO TREATMENT: For the benefit and protection of our patients' health, we require initiation of treatment to commence within 6 months of a treatment plan being created. Our office policy is to not sustain any patient on medications alone without commencing routine or emergency treatment recommended by Jon Douglas Lesan, DDS. We reserve the right to release you from our office if you fail to show up for 2 or more appointments without notice, or have cancelled 3 or more appointments without reason. In this case, you will be notified of your release via mail, by a letter explaining the reason for release.

_____(initialize)

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The office of Jon Douglas Lesan, DDS, RPh, PA will be using electronic medical records, including your photograph, to maintain your health care information. Our office is committed to maintaining the privacy and confidentiality of patient health information in compliance with HIPAA, and will only use your photograph for internal identification purposes.

You may, at any time, withdraw this consent with written notice to our office.

_____**Yes**. I agree to have my photograph taken and stored in Jon Douglas Lesan, DDS, RPh, PA's electronic medical records system. I understand that by checking "Yes" and signing below, I am giving Jon Douglas Lesan, DDS, RPh, PA permission to take and use my photograph in its electronic medical records system for identification purposes.

_____ **No**. I do not wish to have my photograph taken and stored in Jon Douglas Lesan, DDS, RPh, PA's electronic medical records system.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by this consent.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____ _____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE