PATIENT AGREEMENT & CONSENT FORM

I, _____ , understand there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue, at the site of the injection, which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of sensation of the tongue and lip. If this occurs it is often temporary and normal sensation usually returns. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I also understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

The success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to the office of any change in my health status.

I acknowledge that no guarantees or assurances have been given, by anyone, as to the results that may be obtained, and I authorize Dr. Goyal, and/or his staff, to perform the treatment needed.

PAYMENT POLICY

Payment is expected at the time of service. If you have insurance coverage, Allendale Dental will submit claim forms, as a courtesy, while you are expected to pay for any deductible(s), co-pay(s) or uncovered item(s), when services are provided. As the insurance company holds the contract with you, you acknowledge responsibility for all of the charges.

Any amount not paid by insurance is your responsibility. And, any balance that is past 30 days will have a 1% monthly finance charge added to it.

We accept payment by: (Please circle your preferred method of payment below)

Cash   Check   Debit Card   Credit Card

EMERGENCY AFTER HOURS CARE

If you have a dental emergency, and you have called our office after hours, leave a message along with a working phone number where you can be reached.   Please disable your caller ID block so that Dr. Goyal is able to return your phone call.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Allendale Dental's NOTICE OF PRIVACY PRACTICES, and fully understand the "Payment Policy", outlined above, accepting responsibility for all charges, deductibles, co-pays and uncovered items, not paid by my insurance.

_____

Please print patient name   **Relationship to patient**

X _____

Signature of Patient (or responsible party)   **Date**