SMILE ARTISTRY

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible dental health*** requires a "partnership" between you and the dentist. As our "partner in dental health" we ask you to help us in the following ways:

Schedule Visits with the Dentist for Routine Exams and Other Recommended Dental Treatments

I understand that my dentist will explain to me which exams and/or treatments are appropriate for my dental care. I understand I will need to complete these recommendations for the well-being of my dental health. **These exams can detect concerns before they become a big problem.** If I visit the dentist only for treatment of immediate problems and forget to arrange for regular exams, I put myself at risk of letting serious dental problems go undetected. I will schedule regular visits with my dentist to complete re-care exams and to discuss these screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my dentist will want to know how my condition progresses after I leave the office. Returning to my dentist on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my dentist might order dental x-rays, refer me to a specialist, prescribe medication, or even discover and treat a serious dental condition. If I miss an appointment and don't reschedule, I run the risk that my dentist will not be able to detect and treat a serious dental condition. I will make every effort to reschedule missed appointments as soon as possible.

Inform My Dentist if I decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my dentist may make certain recommendations based on what he or she feels is best for my dental health. This might include prescribing medication, referring me to a specialist, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my dental health. I will let my dentist know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your dental health, please ask.

_____

Patient Signature Date

Patient Portal

Our office strives to provide you the best quality care. When you come in for a visit, we wish to provide you with our undivided attention. During office hours, we are in the midst of seeing patients, where communication is vital to a patient-provider relationship. When calls are made into the office, messages are taken and then handled via our staff. Often at the end of a busy day we may have multiple messages awaiting us. Most messages are simple and can be handled immediately; others are more detailed and require a bit more time. If you factor in the difficulty of returning calls and the inability to get in touch with the patient, this "phone tag" system can greatly complicate matters.

In order to make communication easier and more effective, we have installed a PATIENT PORTAL, A WEB BASED OMMUNICATION SYSTEM. Through the portal, and email system, we can document and exchange messages, offer refill requests and answer pre- and post-op questions and send educational material. We will highly recommend that everyone register for this portal. Communication via the portal will get priority and most times can be handled within the same day or next day. The web portal is to be used for non-emergency matters.

I have read the above and consent to use of the portal.

_____ _____

Signature Email

SMS Messaging

I DO give my written consent for Smile Artistry Chino to reach me on my cell phone regarding appointment reminders, test results or any miscellaneous communication.

_____

Patient Signature Date Cell Phone Number

Financial Policy

We would like to thank you for choosing Smile Artistry Chino as your dental care provider. We are committed to providing you with quality and efficient dental care with a smile. In an effort to provide you with the best possible experience during your office visit, we have developed this policy which details our financial requirements to help you understand your responsibilities as a patient.

Insurance Benefits/Deductibles: Knowing your insurance benefits, including co=pays, co-insurances and yearly deductibles is your responsibility and these are to be paid at time of visit. If you have a yearly deductible that has not been met, a deposit towards that visit will be collected at the time of visit. If there is a remainder balance for your visit, once we receive the explanation of benefits, you will be responsible for the balance immediately. Initials _____

Copayments: All copayments are due at time of visit. NO EXCEPTIONS! If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you. Initials _____

Health Plans and Coverage: The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for dental services. Any and all authorizations for HMO plans are your responsibility, if the health plan denies your claim for lack of authorization, the full payment will be your responsibility. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance. Initials _____

Current Information: We require you to bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence.

Records and Copying: There will be a $35 charge for copying records. A records release will be needed.

Returned Check Fee: There is a $30 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment at any time on your account in the future.

Cancellation/No Show Policy: We understand that there may be times when you miss an appointment due to emergencies. We URGE you to call 48 hours prior to cancelling your appointment. Failure to do so may result in a charge of $50. If you “no show” for two consecutive appointments or cancel for a total of four appointments without notification, you WILL Be discharged from care.

Our practice is committed to providing the best possible care for our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Printed name of patient or responsible party Date

_____ _____

Signature of patient or responsible party Date