Advanced Care Dental
WELCOME

Thank you for selecting our dental Healthcare team! We strive to provide you with the best possible dental care. To help us meet your healthcare needs and process your insurance claims, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

NAME_____ SOC.SEC.#_____-_____-_____

Policies/ Disclosures / Authorization

***** Broken appointments will be charged $50.00 unless cancelled within 48 hours notice. More than two missing appointments will result in discontinue our services.**

All records, X-ray, photographs, etc… are the property of the clinic.

Insurance Claim Processing

We will help you to make most out of your plan, but you are sole responsible for the payment of treatment. Every individual has different limitations and benefits of their insurance policy. Please be well informed of your insurance coverage. If the payment is not received within 30 days, a finance charge of 1% per month is applied. If full payment is not made within 90 days the account will be turn into collection.

Disclosure Initial _____

I hereby consent to the use and disclose of health care information regarding me/patient for the purposes of the healthcare operations. I/patient have the right to review Advanced Care Dental's privacy notice and to request restrictions on the clinic's use and disclosures of the healthcare information and to revoke this consent to release information.

Authorization Initial _____

I hereby authorize ADVANCED CARE DENTAL to process payment whenever services are rendered.

I the undersigned (Patient or legally responsible party**) authorize dental treatment and assume full financial responsibility including insurance co-payment and deductibles.**

Patient Signature_____ Date_____

Parent/Guardian/ Other Signature _____ Date _____