

Kelli Slate, D.D.S., P.A. Consent Forms

Patient Name: _____ **Date:** _____

Welcome to the practice of Dr. Kelli Slate. We are both honored and privileged to be your dental home. Please review the following carefully prior to completing with your signature.

Dr. Slate will request diagnostic records only when necessary. These records may include x-rays, study models, photographs or other items which are necessary to provide you with a thorough diagnosis.

May the necessary diagnostic records be taken at your dental visit? _____

Financial: Without prior financial arrangements, payment is required at the time of your appointment. Should you need financial arrangements, please make these arrangements when your appointment is scheduled.

Dental Insurance: All dental reimbursement is determined only by your dental carrier following treatment completion. Your dental insurance does not guarantee payment to Dr. Slate at any time. Without previous financial arrangements, **payment in full** is required at the time of service with your insurance reimbursement being sent directly to you. If you have existing financial arrangements, your insurance check will be sent to Dr. Slate where applying those benefits to your account will reduce your final payment.

Appointments

Honoring previously scheduled appointment times is a partnership between you and our practice. We are committed to honoring your time with us and expect the same in return. Should an emergency arise in which a change of appointment time is needed, please notify us immediately. Cancellations within 2 business days of your scheduled appointment or failing to arrive for your scheduled appointment will result in a non-refundable \$55.00 per hour fee.

I acknowledge the guidelines for appointment changes. _____

Treatment

During the course of treatment, should it be necessary to alter the agreed upon treatment of choice, Dr. Slate will pause in treatment to update you fully, educating you on the options assisting you in making an informed decision.

A parent or legal guardian must accompany and remain present during treatment of any patient under the age of 18 years.

I authorize the release of all information regarding my treatment to any other doctor or dentist to whom Dr. Slate refers me for additional treatment or consultation.

This signature will serve for all my family members for the above information.

Patient, Parent or Legal Guardian

Date