YOUNG DENTAL GROUP
FAMILY DENTISTRY

PATIENT NAME _____ DATE OF BIRTH _____

EMAIL ADDRESS _____

HIPAA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

_____ INITIAL

DENTAL MATERIALS FACT SHEET

I have received a copy of the Dental Materials Fact Sheet as required by law.

_____ INITIAL

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

I agree that Young Dental Group may communicate with me electronically at the email address above. I am aware that there is some level of risk that third parties may be able to read unencrypted emails. I can withdraw my consent to electronic communications at any time.

_____ INITIAL

At Young Dental Group, our goal is to provide dental health care that exceeds the standards of our peers. We will provide this care in the most courteous, cost effective, and conscientious atmosphere. It is important that you are involved in your care. This involvement starts with a clear understanding of our office policy that **payment for dental services is *due on the day services are rendered.***

DENTAL BENEFIT PLANS: As a **courtesy**, Young Dental Group will process insurance claims on the patient's behalf and help the patient **estimate** the covered benefit amount. **Young Dental Group is out of network for all plans except Delta Dental Premier**. I acknowledge that any amount not paid by my benefits plan is the my responsibility.

_____ INITIAL

CANCELLATION POLICY: Time has been specifically reserved for my appointment. Appointments must be cancelled at least **48 hours** prior to appointment or a **fee will be applied: $65 for failed hygiene appointments, $100 $100 for failed doctor appointments.** Monday appointment cancellations must be made by the prior Friday by 5:00PM.

_____ INITIAL

FINANCIAL POLICY: Young Dental Group has permission to bill my credit card on file for any outstanding balance on my account.

_____ INITIAL

CREDIT CARD NUMBER _____ MONTH _____ / YEAR _____ CVV CODE _____ BILLING ZIP _____

I certify that all information is complete and accurate. I authorize Young Dental Group to collect payment noted above by processing a charge to the credit card listed above. By signing below I certify that I am the authorized signer and will be responsible for all charges authorized by this form.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY _____ DATE _____

PRINTED NAME OF PATIENT/RESPONSIBLE PARTY _____