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.

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INITIAL

DENTAL MATERIALS FACT SHEET

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

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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.

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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.

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INITIAL

CANCELLATION POLICY: Time has been specifically reserved for my appointment. Appointments must be cancelled at least **48 hours** prior to appointment or a **$50 fee per appointment will be charged** if I fail to show for a scheduled appointment or cancel with less than 24 hours notice. Monday appointment cancellations must be made by the prior Friday by 5:00PM.

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INITIAL

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

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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

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PRINTED NAME OF PATIENT/RESPONSIBLE PARTY