# Patient Policy Consent Form

**Dr. Mark Brisely, DDS**
**618 Glennerye**
**Laguna Beach CA 92651**

Thank you for selecting us as your personal dental team. To promote a long term and mutually satisfying relationship, we would like to explain our office policy regarding treatment. Insurance, appointments, and fees. PLEASE read this carefully and ask any questions or concerns you may have before treatment is rendered. SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO TERMS OF THIS AGREEMENT.

**TREATMENT:** You will find our entire staff is dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at anytime.

**INSURANCE:** If this office is able to accept your insurance company's assignment, the patient is still FULLY RESPONSIBLE for all charges for your treatment rendered.Your insurance MAY NOT COVER the services or may only PARTIALLY COVER them and any ESTIMATE given by this office is considered a guideline until the final insurance payment is received and the patients account is reconciled. The office can make NO GUARANTEE of the actual payment by your insurance company.

**MISSED APPOINTMENTS:** When we schedule your appointment , the time is reserved exclusively for you. When you fail to notify us your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. **We request that you give us at least 24 hours notice when you realize you are unable to keep an appointment. When the requested notice is not given, a fee of $30.50 per half hour scheduled will be charged**. For those who schedules make it difficult to effectively plan ahead, we ask you do NOT schedule an appointment in advance, but call us the let us know of the day you are able to come in and we will be happy to provide services at that time if our schedule can accommodate you.

**PAYMENTS DUE AT TIME OF SERVICES**: We accept cash, personal checks, all major credit cards, and Care Credit. We have options available for patients requiring extensive dental treatment.Please ask our front office staff for information. Our office reserves the right to adjust our procedure prices without notice.

PROSTHETICS: Crowns,Dentures, Bridges,etc. **FAILURE BY MEMBER TO RETURN FOR THE DELIVERY OF THESE ITEMS WILL BE SUBJECT TO DOCTORS TIME AND LAB FEE CHARGES._____Initials.**

**SERVICE CHARGES:**
**1. Monthly billing:** You will receive a statement each month for services not covered by your insurance with a balance that is due. This is due to the fact YOU, not the insurance company are responsible for the amount not covered. Any balances outstanding 60 days or longer will have a $5.00 dollar processing fee every month until charges are cleared from the account.

**2.Returned checks:** There will be a $20.00 charge applied for all returned checks. The check must be picked up personally and cash must be paid to cover the check and return fee.

I have read and understand all office policies.

**Signature**_____ **Date**_____
patient signature or legal guardian if patient is a minor