FOREVER SMILE
General & Cosmetic Dentistry

5757 Wilshire Blvd, Ste 350
Los Angeles, CA 90036
(323)634-9004

Office Policies

**CANCELATIONS:** When you schedule an appointment at our office, time is set aside specifically for you and your treatment. It is very important that you keep your appointment. We require at least 48 hours advance notice if you must cancel or reschedule your appointment. Missed appointments and those canceled within less than 48 hour notice will be subject to a fee. No further appointments will be made until missed appointment fee is paid. If more than one cancellation in less than 48 hours within a 12month period takes place, in order to reschedule for service, appointment must be paid in full at time of rescheduling.

**PAYMENT AND TREATMENT:** Once a treatment plan has been established, in order to schedule for the treatment, a 25% deposit is required to reserve the appointment time with the designated provider. In the event that the appointment is canceled in less than 48 hours, the cancellation fee will be deducted from the deposit. If a cancellation is made with at least a 48 hour advanced notice, no part of the deposit is taken and is fully transferable to the rescheduled appointment time.

**INSURANCE:** If you have dental insurance, our staff can give you an estimate of your insurance benefits and your co-payment, which is due at the time of service. Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. It is your responsibility to notify our office of any information changes when they occur. Verification of your insurance benefit is not a guarantee of payment even if a pre-authorization of services has been approved. Any charges not paid by insurance is the responsibility of the patient. When insurance is involved, we are contractually obligated to collect co-pays, co-insurance, and deductibles, as outlined by your insurance carrier. By signing below, I agree that if my account remains unpaid by me for 30 days, it may be referred to a collection agency and/or attorney and that I am responsible to pay for all cost incurred, including collection fees and attorney fees. Furthermore, I and/or my dependent(s), assign all benefits directly to Forever Smile. I authorize the use of my signature on all insurance submissions. Forever Smile may use my health care information and may disclose such information to the above insurance company (ies) and their agents for the purpose of obtaining payment for services.

**NOTICE OF PRIVACY PRACTICES & RECEIPT OF DENTAL MATERIALS FACT SHEET:**

By signing below, I acknowledge that I have received and understand this office's Notice of Privacy Practices. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If changes occur, the office will provide me with a revised notice upon request. Also, by signing below, I acknowledge that I have received a copy of the Dental Materials Fact sheet, as required by law.

Patient Signature:_____ Date:_____

Printed Patient Name:_____

(If minor) Relationship to Patient:_____