OASIS FAMILY DENTISTRY

Appointments

Here at Oasis Family Dental we value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, kindly provide us at least **two working days advance notification** so that we may use out time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. **Unless given the required notice, a cancelled or broken appointment charge of $50 per hour reserved may be applied.**

Financial Policy

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment. Should a patient have dental insurance with an assignment to Drs. Garcia and Gortari at Oasis Family Dental, the estimated patient portion will be the amount due that day. Our practice is committed to providing the best dental treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of all charges regardless of any insurance company's arbitrary determination of usual and customary rates. **In order to accommodate our patients, Oasis Family Dental is an In-Network Provider for most major dental insurances.** Please be sure to check if we are a Preferred Provider for your plan.

Payment Options

1. For your convenience we accept Cash, Check, Visa, Mastercard, Discover, CareCredit and CitiHealth Card.
2. We also offer short and long term financing. Please inquire at the front desk about interest free options.

Additional Fees: **1)** Overdue balances in excess of 60 days are subject to a $5 per month rebilling fee. Any account that remains outstanding will be forwarded to a collection agency for further collection action and all costs associated with these collections proceedings will be the patient's or guarantor's responsibility. **2)** Returned checks will incur a NSF fee of $35.

General Consent to Treatment: I agree and consent to a dental examination by Dr. Garcia and/or Dr. Gortari. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees expressed or implied as to the results of any procedures or dental treatment performed.

Release of Information: I authorize Dr. Garcia and/or Dr. Gortari to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or health professionals.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Dr. Damien Garcia and/or Dr. Lisa Gortari at Oasis Family Dental.

Photography: I authorize Dr. Damien Garcia and/or Dr. Lisa Gortari to take photographs of me to help me better understand my current dental condition and possible treatment options.

Photo/Video Release:

I hereby grant Oasis Family Dental permission to use diagnostic photographs and records in publications and/or on the office website, blog, Facebook and Twitter for informational or marketing reasons. I understand that I have the right to request, in writing, removal of the photo and/or video from the website within 30 working days of receipt of the request by Oasis Family Dental. I understand that this photo and/or video may be used in office publications or on a website designed to promote dental services as well as offer information and resources. By signing below, I acknowledge my understanding of the above and grant my permission for use of the photograph(s) and/or video(s).

☐ **I chose to not release any photograph(s) or video(s) at this time.**

I have read and understand the *Appointment Policy, Financial Policy and General Consent of Treatment* and will comply with Oasis Family Dental's office policies. I authorize the release of information and photographs take of me as described above. I also hereby acknowledge that I have received a copy of this practice's *Notice of Privacy Practices*. I also understand that I may ask any questions I might have regarding this notice.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE:_____
Patient Name: _____