KIM LE, D.D.S

990 U.S. HIGHWAY 287 NORTH # 112
MANSFIELD, TX 76063
OFFICE: (817) 473-6677 FAX: (817) 473-6695

OFFICE POLICES

It is your responsibility to keep all appointments. If you cannot keep a designated appointment time, please give the office a 24 hour notice. **Missed appointments are subject to a $25.00 charge.**

Payments are due at the time of visit. This includes all Co pay's coinsurance, and deductible amounts, for your convenience we accept Cash, Check, Visa, and MasterCard.

Return checks "any bad check can and will be turned over to the justice of the peace if the account is not reconciled within 20 days."

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

INSURANCE POLICIES

We participate in several dental plans. It is *your responsibility* to verify that we do participate on your plan. It is also your responsibility to know the terms, limitations, and benefits of your plan.

If we file insurance on your behalf, we need a copy of your current insurance card; you are required by your insurance company to pay all co pay's coinsurance, and deductibles which are due and payable at the time of service.

Verification of your insurance does not guarantee payment. Payment is subject to review by your insurance company. Payment is determined upon the actual receipt of the claims by the insurance company. If your insurance denies payment for services, you will be billed and it is your responsibility to pay for the service within 45 days of the date of treatment. It is your responsibility to contact your insurance company to dispute any denial, or nonpayment issues.

We will be happy to assist you in preparing forms or printing receipts for you to file with your insurance company.

I, the insured/dependant, have read the above and understand the policies regarding office and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services provided.

____ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

FINANCIAL AGREEMENT

I, ______________________, understand that any service performed for my dependant or me by Dr. Kim Le or her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Kim Le office responsibility to collect from my insurance company.

Dr. Kim Le office will file an initial insurance claim on my behalf as a service to me at no additional cost. If my insurance carrier has not responded within 45 days of the date of the service the entire fee for the service is due and payable by me. I understand any remaining balance regardless of the amount of the insurance payment is my responsibility.

____ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

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DENTAL PRACTICE AGREEMENT

1. **Health Information**
   I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.
2. **Drugs, latex and Medicines**
   I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heart beat and, depending on my health, may be dangerous for me.
3. **Needle Stick**
   If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.
4. **Filings, Crowns and un-anticipated Root Canals**
   Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.
5. **Root Canals can fail**
   Root Canals can fail and may require additional treatment or I may end up having to the tooth extracted.
6. **Porcelain crowns, veneers, bonding and cosmetic fillings**
   Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.
7. **Gum Treatment and Requesting "Just a Cleaning"**
   If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, <u>I will not insist that I simply just need to get a cleaning</u> (prophylaxis).
8. **Extractions and Surgery**
   I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life threatening such as post surgical infection or anaphylaxis.
9. **Fee for Additional or Specialty Care**
   I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.
10. **Limitations of Insurance Coverage**
    There are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. <u>I agree to be financially responsible for what insurance does not cover.</u>
11. **24 Hour notice of cancellation**
    I agree to give 24 hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the day (or weekend) before is not sufficient notice.
12. **Requesting Record Transfers**
    Professional courtesies are between dentists. I agree not to requests records until I have a new dentist.
13. **Hygiene Appointments**
    If I am more that 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

I do not expect guarantees in dental care. I have read the above and consent to agreement.

______________________________ ____________________
PATIENT / GUARDIAN SIGNATURE DATE