Welcome to Ironwood Family Dentistry

Authorization of Services/Release of Information

I understand that at some point in time my records, including x-rays may be forwarded to other agencies including referred Doctors, insurance agencies and collection agencies. This will also include your own personal request to transfer records if need be. **Please note: In order to release x-rays your Account Balance MUST be paid in full. By signing below , it verifies you have read the above information and agree to our offices terms.**

_____ _____

Signature Patient/Guardian Date

Attendance Policy Agreement

We are glad you have chosen our office and we look forward to meeting your needs. When you schedule an appointment in our office we reserve a slot especially for you. In order to provide you with the best possible service, we request that you arrive to your appointment on time. We provide you with the best possible service; we request that you arrive at your appointed time. We pride ourselves on running true to schedule because we know your time is valuable. If you must cancel your appointment, please call our office at least 24 hours in advance. If we do not receive a 24 hours notice we reserve the right to charge your account $25.00 reinstatement fee to reschedule.

By signing below, it verifies I have read and hereby agree to comply with the attendance policy

_____ _____

Signature Patient/Guardian Date

Finance Charges and Collection Fees

I understand that any unpaid balance that remains past 45 days will accrue a 3% finance charge on a monthly basis until balance is paid in-full. I also understand that if the balance goes with not attempt at payments for 90 days Ironwood Family Dentistry reserves the right to review my account and determine if an outside collection agency will be used to collect my balance. If this occurs I understand an additional fee of $20 will be added to my total balanced owed.

_____ _____

Signature Patient/Guardian Date

Amalgam Restoration/Filling Consent

I understand that my insurance company may not reimburse fillings at quoted estimate, due to some insurance companies paying based on amalgam fees. In an effort to provide the best care we only place composite fillings which can lead to a difference in estimated fees. I acknowledge I am responsible for the difference in fees in the event this is my insurance company's policy.

_____Signature Patient/Guardian _____Date