Maryam Jackson, D.D.S.

743 E. Chapman Avenue Orange, CA 92866 (714) 997-5495 smilesoforange743@gmail.com

Patient Name: _____ **Date:** _____

Please read and initial where indicated.

Patient Acknowledgements

A. I have received a detailed copy of the ***Notice of Privacy Practices*** written in plain language from the office of ***Maryam Jackson, D.D.S.*** The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. ☐

B. I have received a copy of the ***Dental Materials Fact Sheet*** dated May 2004, as required by law. This fact sheet contains a summary of information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science. ☐

Office Financial Policy

We are committed to the successful completion of your proposed treatment and look forward to a lasting professional relationship . It is important to us that clear communication of our Financial Policy is established from the beginning. Please review the following guidelines. If you have any questions regarding these guidelines, or our fees, we would gladly discuss them with you in more detail. We ask that payment be made at the time of service. If applicable, we are happy to bill your dental insurance plan(s) for covered services and wait for their approved portion of reimbursement to us, however, any insurance estimated co-payments, deductibles, non-covered services, etc., will be collected at the time of service. Any other financial arrangement must be discussed with our Office Manager in advance of services performed.

We accept the following methods of payment:

- Cash or Personal Check
- Debit Cards
- Visa, MasterCard and Discover
- Care Credit (3rd party Healthcare Financing—ask our Office Manager for details)

I understand and will abide by this Office's Financial Policy as stated above. ☐

Appointment Cancellation Policy

Last minute cancellations or missed appointments are costly to everyone! We understand that things come up from time to time that may prevent you from keeping your scheduled appointment. We appreciate your consideration in providing at least **48 business hours'** notice when needing to cancel or reschedule an appointment to avoid a $75.00 Cancellation Fee. Please keep in mind that we do not have office hours on Fridays, Saturdays, or Sundays, and will not be made aware of your need to change an appointment until Monday morning if you have only left a voice message after office hours. Please contact our office during normal business hours if you need to change an appointment. Our Office hours are: Monday, Tuesday, and Wednesday 8:30--5:30PM, Thursday 8:30-2:30PM. Confirmed appointment "No Shows" will also be subject to a Cancellation Fee. We can help keep you on track with convenient text, email, or telephone appointment reminders. Please ask our Business Office to set up your appointment reminder preferences.

I understand and will abide by this Office's Appointment Cancellation Policy as stated above. ☐

Insurance

If applicable, your insurance coverage is a contract between you and your insurance company or employer. As a courtesy, we will gladly bill your insurance company for any covered services. Estimated co-payments, deductibles, etc., if any, will be requested at the time of service. Your initials here authorize us to release any pertinent information to your insurance carrier, which may be required for the accurate processing of your dental claims.

I understand and will abide by this Office's Insurance Policy as stated above. ☐