PINE COVE
FAMILY & IMPLANT DENTISTRY

1560 E. Debbie Ln #108
Mansfield, TX 76063
Phone: 817-453-8520
Fax: 817-453-8522

We value you as a patient and appreciate you trusting us with your dental treatment. In order to provide you with the best care possible, we have established the following policies with your safety and interest in mind. Please review the following and sign this agreement confirming you have read and accepted these policies. If you have any questions, please allow one of team members to provide you with an answer before signing.

**Hours of operation:**

- Monday: 10:00am – 6:00pm
- Tuesday and Wednesday: 8:00 am - 4:00 pm
- Thursday: 7:00 am – 3:00 pm
- Friday: 10:00 am – 6:00 pm

**Cancellation and Re-scheduling:**

- We value and respect your time. Scheduled appointments are reserved especially for you and the proper amount of time is carefully considered and scheduled for each procedure. As such, **we require at least 48 hours notice for ANY cancellation or change of appointment.** This will allow us adequate time to meet scheduling needs for another patient. Any re-scheduled appointment within 24 hours of appointment time is considered as a No-Show.
- **If you have more than 2 No-Shows in a 4 month period we will no longer be able to reserve scheduled time for you.**
- We understand that emergency situations occur that prevent patients from giving advance notice of the need to cancel an appointment. We will consider such situations on a case-by-case basis.

**Treatment of Children and Minors:**

- Our standard policy for patients under the age of 18 (minor) is that a parent or legal guardian must be present throughout the entire treatment. For patients of record, we will allow you to leave temporarily if necessary for routine dental procedures such as cleaning and checkups. For other procedures, please inquire BEFORE the appointment if you cannot be physically present. This policy is to ensure the safety of your child/children.

**Consent for Treatment**

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostics aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

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## Payment

**We accept the following forms of payment. Payment is due at the time service is rendered:**

- Visa
- Mastercard
- Discover
- Personal checks
- Cash
- CareCredit
- Lending Club

## Dental Insurance

- Individualized quality dental care and building a lifelong relationship with you is important to us. Our professional services are rendered to you as the patient and not to your insurance company. Diagnoses of your dental needs are not based upon what your insurance company will allow but rather individual needs. Our office will prepare the patient's insurance forms and submit them electronically as a courtesy. Any remaining balance that is not covered by your insurance plan will be your responsibility. We will do our utmost to help you derive the maximum benefits to which you are entitled. Any insurance dollar amounts or percentages discussed with you by representatives of Pine Cove Dental are ESTIMATES of your benefits only. In signing this agreement, you understand that your insurance company determines what they will pay upon receipt of your claim; there is no guarantee expressed or implied by Pine Cove Dental that any specific insurance payment amount will be paid. Therefore, you are directly responsible for 100% for all services rendered in the absence of payment from your insurance company.
- We allow up to 45 days for your insurance company to make payment. After this time, the claim will be closed and you will be responsible to pay for your balance in full. All inquiries and necessary follow up for reimbursement from your insurance become your responsibility.

**Treatment Options:** I acknowledge that it is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed, and/or appointments are missed, adverse results could affect my dental health.

**Treatment Fees:** Fees are valid for 30 days from treatment plan presentation and are subject to revision. Treatment could be altered if your dental needs change. You will be notified of any change(s) in your treatment plan.

By signing this form, I acknowledge, understand, and agree to the above policies and obligations. I have had full opportunity to discuss and ask any questions regarding the dental treatment, and all questions have been answered to my satisfaction.

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| Patient Name (printed) | Patient/Parent/Guardian Signature | Date |
| Witness Name (printed) | Witness Signature | Date |