**Huntington Dental Arts**

**Nicolas Nieto, D.M.D, P.A.**

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**Office Policy’s**

We have found that a clear agreement on finances BEFORE treatment begins results in fewer misunderstandings. With that in mind, we have carefully developed the following financial information. Please read and understand the following regarding payment of dental fees. At the end of this document, you will be asked to sign in agreement and understanding of this document. You will be provided a copy for your records if requested.

**ESTIMATES**

It is to everyone’s advantage that our patients be as completely informed as possible. Therefore, it is our policy to provide a Treatment Plan with estimated Fees before any work begins. All estimates are guaranteed for 90 days. Please understand an estimate is just that…an estimate. We try to carefully plan all treatments, but during the course of a treatment, additional, alternative or more costly treatment may become necessary. We will, of course, inform you of such an event before continuing.

**PAYMENT METHODS**

We accept cash, personal checks, money orders, Traveler’s checks, Discover, MasterCard and Visa. For treatments over $1000, Financing is available through Care Credit, pending approval.

**ARRANGEMENTS**

For all Non-Insured/Non-Financed patients, all services are PAYABLE IN FULL AT TIME OF TREATMENT. As an incentive, we office a 5% discount for any services totaling $1000 or more if payment is made in full by CHECK or CASH ONLY. Credit cards are excluded from this incentive. This offer is good for up to 30 days after Treatment Plan has been presented.

**BROKEN/CANCELLED APPOINTMENTS**

Missed appointments are a loss for everyone! Please understand that when an appointment is made, that time is reserved especially for you alone. If your appointment is broken or cancelled 48 hours prior to the appointed time we find it necessary to charge a fee equal to the fee allotted to that appointment time. Our practice does not double-book patients as in high-volume offices. Emergencies permitting, Dr. Nieto desires to spend treatment time exclusively with you at your appointment.

**INSURANCE**

Insurance coverage is a CONTRACT BETWEEN THE PATIENT AND THE INSURANCE CARRIER. It is a benefit to the patient and should be considered only an adjunct to dental treatment. It does NOT and never was INTENDED to pay for all of your dental treatment. As a convenience to our patients, we will file your insurance claims with your carrier. We will determine from your insurance company the amount of coverage for your procedure. You will be responsible for payment of your co-insurance and deductible amount.

-Over-

The following information is required to process your claims:

* Dental Insurance Carrier Name and Address
* Dental Plan Name
* Dental Group Number
* Employer Name and Address
* Second Plan Information. (Note: When two carriers are involved, it is required to disclose the double coverage information to BOTH carriers.)

**RETURNED CHECKS**

There is a $35 charge for ALL returned checks.

It is our sincere intention to provide the best dental care available at the most reasonable fees. Also, we hope that by providing you with the above information, no misunderstandings will arise as we proceed with your treatment. Please feel free to ask questions or make suggestions. My staff and I will assist you in any way possible.

I have read, understand and agree with the above information.

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Patient/Responsible Party Signature Date

**CONSENT TO DENTAL PHOTOGRAPHY**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient), authorize Dr. Nicolas Nieto DMD, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

• Dental Records

• Dental Research

• Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books

• Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

o Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient/Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_