Records release request for treatment purposes

Dr._____

Address_____

City_____State_____ZipCode_____

Telephone number_____

I, _____ authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to

Douglas D. Means D.M.D., Inc.

1710 Cooper Foster Park Road Ste A

Lorain, Ohio 44053

440.282.3642

_____ _____

Signature of patient, guardian or personal representative Date

_____ _____

Print name of patient, guardian or personal representative Relationship to patient

Douglas D. Means D.M.D., Inc.

Informed Consent for Treatment

I understand the treatment and financial responsibility involving restorative procedure including, but not limited to, filling/crown/bridge/dentures/partials/implants, etc. There are certain risks that are to be assumed when having restorative treatment. There is the possibility of failure to achieve the results which may be desire or expected. I agree to assume those risks which may occur even though great care and diligence will be exercised by Dr. Douglas Means, in rendering my treatment. I understand that everyone responds to treatment differently and the risk and severity of these risks will differ from person to person. These risks include, but are not limited to, the following: Reversible or irreversible pulpal irritation, pain, possible root canal therapy and in rare case, extraction. I also understand that home care and periodic evaluation is essential to properly maintain restorations. Failure to do so may result in complications with or the failure of these restorations.

I understand it is my responsibility to notify this practice should any undue or unexpected problems occur or if I experience any problem in relation to the treatment rendered or the services performed.

INFORMED CONSENT: I have been given the opportunity to ask any question regarding the nature and purpose of restorative treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risk which may be associated with any phase of treatment in hopes of obtaining the desired and/or and satisfactory results. By signing this form, I am freely giving my consent to authorize Dr. Douglas Means, and his team involved in rendering treatment, he deems necessary or advisable in treating my dental conditions, including the administration and/or prescribing of any anesthetic and/or medications.

_____ _____ _____

Patient name (print) Signature of patient or guardian Date

Douglas D. Means, D.M.D., Inc.

Financial Policy

At Dr. Douglas D. Means' dental office , we strive to provide our patient with the finest care and customer service. In order to do so, we ask that we and our patients work together. Please take your time to read this policy carefully. If you have any questions, our friendly team would be happy to answer questions you may have.

Payment can be made by a variety of methods such as: check, money order, all major credit cards and Care Credit. ***We ask that all co-pays be paid prior to your appointment.*** *Although we strive to give you an accurate co-payment for services, it is almost impossible for us to obtain an exact dollar amount even when a pre-authorization has been obtained for treatment. We do our best to provide you with the most accurate information based on the estimates and information given to us by you along with your insurance carrier. But please be advised that the fees are only estimates at the time of service. Treatment may vary during the course of the appointment, therefore varying your co-pay amount. If an overpayment should be made, we will either reimburse you as the patient or apply to credit to another family members balance.*

We work hand with our patients' insurance providers to maximize and make efficient use of your dental benefits. We are happy to submit claims to insurance carriers as an extended service to our valued patients. However, after 60 days, any remaining balance will be considered the responsibility of the patient.

Our accounts run on a 30 day billing cycle, should your account balance remain unpaid for 90 days, a $5.00 re-billing fee will be applied. If after 90 days, no payment has been made on the account, the account will then be turned over to our collection agency and the account owner will be dismissed from the practice. We will make every effort to work with you on any unpaid balance and the above mentioned will be a last attempt.

As another courtesy and extended measure, we take in order to provide you with great customer service is we will confirm your appointment date and time by email, phone call and/or post card. Emails and phone calls may vary from a 24-72 hour notice and post cards, a 3-6 week notice. We do this because we also ask that you give us a 24 hour notice if you are unable to keep your appointment. Douglas D. Means, D.M.D., Inc., reserves the right to apply a $25.00 cancellation fee to your account if sufficient cancellation time was not given. We do understand that unforeseen circumstances and emergencies arise, therefore, exceptions can and shall be considered at our discretion.

Thank you for your trust and understanding. We look forward to building a lasting dental relationship with you.

Douglas D. Means D.M.D., Inc,

I have read and understand the financial policy

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signature *Date*