Dental Serenity

OFFICE POLICIES

Thank you for choosing Dental Serenity. Our primary mission is to provide our patients with the highest level of dental care, while creating an exceptional experience. All patients must complete our office policy forms prior to seeing the doctor or hygienist. A valid driver's license is required.

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITY FOR TREATMENT COST

We are happy to bill your insurance company as a courtesy to you. For us to bill your insurance properly, it is necessary for you to provide accurate and complete information at the time of your visit. Under no circumstances will any insurance company guarantee reimbursements or coverage prior to treatment. While your insurance company is concerned with limitations and policy issues in relation to the premiums paid, our concern is only for your health. ***Please understand that the balance of your treatment, regardless of your insurance compensation is your responsibility***.

_____	_____	_____
Print Patient Name (Guardian if Minor)	**Signature**	**Date**

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I _____ acknowledge that I have **received and read the Privacy Notice** and understand my rights contained in the notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

_____	_____	_____
Print Patient Name (Guardian if Minor)	**Signature**	**Date**

Office Use Only: ☐ Refused to Sign ☐ Communication barrier prohibited obtaining the acknowledgement
☐ An emergency prevented obtaining the acknowledgement ☐ Other

CONSENT TO SHARE INFORMATION

I hereby authorize the sharing of personal health information with:

____ Any other healthcare related professionals or healthcare insurance providers

____ Specifically:

Name: _____Email:_____ Phone:_____

Name: _____Email:_____ Phone:_____

Name: _____Email:_____ Phone:_____

I hereby request that my information *NOT* be shared with the following:

Name: _____Email:_____ Phone:_____

Name: _____Email:_____ Phone:_____

Name: _____Email:_____ Phone:_____

Dental Serenity

HYGIENE CANCELLATION/NO-SHOW APPOINTMENT POLICY

Dental Serenity is committed to providing you with quality customer service and patient care in a timely fashion. We understand that unplanned situations may arise where you may need to cancel an appointment. If that happens, we respectfully ask for scheduled hygiene appointments to be canceled within Two (2) Business Days in advance to allow us adequate time to fill your appointment time.

Our hygienists want to be available for your needs as well as the needs of other patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

- Cancellation or rescheduling of an appointment with **Two (2) Business Days** will result in **no charge**.
- A failed appointment is an appointment that is canceled/rescheduled with less than **Two (2) Business Days**' notice or an appointment where a patient does not show.
- **There will be a charge of $75 for cancellation or rescheduling with less than Two (2) Business Days' notice.**
- If a patient fails to show up **within 20 minutes of their scheduled appointment time it may be considered a cancellation and a charge of $75 will be applied. The patient will not be seen and will be rescheduled.**
- After **two (2)** failed appointments, we may require a deposit of up to 100% that will be applied to your appointment, to reserve any further appointments.
- After **three (3)** failed appointments you risk being moved to only same-day appointment bookings.

To cancel or reschedule your hygiene appointment please call our office using the number below. If you do not reach the scheduling coordinator you may leave a detailed message including your name, number, and your scheduled appointment time.

Alexandria: (703) 751-7600
Dumfries: (703) 445-9600
Washington D.C.: (202) 296-7455

_____	_____	_____
Print Patient Name (Guardian if Minor)	**Signature**	**Date**

COMMUNICATION PREFERANCE

Please check the box below to give your consent and opt in to receive text messages from our dental office. By opting in, you agree to receive appointment reminders, important updates, and exclusive offers via text message. Standard messaging rates may apply.

☐ **I consent and opt in to receive text messages from Dental Serenity.**

You can opt out at any time by replying STOP to any message. However, please be aware *opting out will prevent you from receiving any future automated voice, email or text appointment confirmation messages.*

_____	_____	_____
Print Patient Name (Guardian if Minor)	**Signature**	**Date**