AHMAD SOOLARI, D.M.D, P.C.

We expect our patients to follow office policies:

CONSENT TO DENTAL TREATMENT:

I request and authorize Dr.Soolari's office to perform or assist in all dental services. I have been given no guarantees or assurances of any sort by anyone as to the results that may be obtained. I understand that unforeseen conditions or circumstances may arise during the course of any procedure or treatment. Hence, I consent to and authorize the performance of any care, procedure, or treatment that the dentist reasonably believes necessary or advisable as a result of these unforeseen events. In addition, I consent to the administration of any anesthetic that the dentist deems necessary. I also understand that there are risks involve with the administration of anesthesia. Photographs are taken as part of patient's case documentation; I consent to having my mouth photographed. The photographs are the sole property of Dr. Soolari. **Osteoporosis: taking medication (Bisphosphonate) by injection or even orally will predispose you to develop a non healing lesion in the jaw known as osteonecrosis of the jaw (ONJ).**

_____ _____ _____

PRINT NAME SIGNATURE DATE

ASSIGNMENT AND RELEASE:

I hereby assign Dr.Soolari's office all my medical, dental and/or surgical benefits to which I am entitled for service rendered. This assignment is to be considered as valid and facsimiles as original. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____

PRINT NAME SIGNATURE DATE

FINANCIAL AGRREMENT:

I understand that insurance reimbursement is only an estimate. I am ultimately responsible for any fees incurred during treatment. I understand this office does not operate on the assumption that insurance will reimburse me for the treatment rendered. Remember that co-payment (the portion that is not covered by your insurance) and yearly deductible is due at the time of the visit. Please be aware that your insurance is a contract between you and your insurance company, and we are not a party to that contract. It is your responsibility to make sure that you are covered at the time of service. If for any reason your insurance company does not cover a procedure or denies your total charges, IT IS YOUR FULL RESPONSIBILITY TO PAY FOR THE SERVICE. If your insurance company has not made payment within 60 days of billing, the balance will become your responsibility. An outstanding balance will be send to collection agency. The cost of this service is on you.

_____ _____ _____

PRINT NAME SIGNATURE DATE

BROKEN APPOINTMENT & RELEASE OF RECORDS (Radiographs, Charts, etc.):

Please notify us at least 24 hours in advance if you are unable to make your appointment. We have set aside this time for you and if you do not inform in advance BROKEN APPONTMENT CHARGE of $35.00 for routine appointment, $50.00 for surgical and $100.00 for implant surgical appointment WILL BE APPLIED TO YOUR ACCOUNT. To have your records released, the office policy is to charge $25.00 for radiographs. $0.75/per page for record pages. Any administrative work beyond first visit will have a charge of $20.00

_____ _____ _____

PRINT NAME SIGNATURE DATE

RECORDS:

I authorize photos, x-rays, or any other viewing of my care and treatment during or after its completion to be sent to your medical/dental doctor, dental insurance (if you have them), Doctor to Doctor presentations, teaching and to be used for advancement of dentistry (such as publication). This is to provide you with the best dental care possible and to inform your General Dentist with the progress of your treatment in our office. I understand all records pertaining to my care are the sole property of Dr. Soolari.

_____ _____ _____

PRINT NAME SIGNATURE DATE

INFORMATION FOR FEMALE PATIENTS:

I have been informed that taking antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing the conception of pregnancy.

_____ _____ _____

PRINT NAME SIGNATURE DATE

MINOR/CHILD CONSENT:

I._____, being the parent or guardian of the above named patient, do hereby request and authorize Dr. Soolari's office to perform all dental services including but not limited to X-rays, and administration of anesthetics as deemed advisable by the doctor. I am also financially responsible for all the charges for the services rendered to my child.

_____ _____ _____

PRINT NAME SIGNATURE DATE