Patient Name _____ Date of birth _____

No show/cancellation policy

One of the great things about our office is that when you schedule your appointment, we hold that time specifically for you! Thus, our office must charge a fee of $60.00/hour of scheduled time (ex: 1.5 hours equals $90) to your account for all "no-shows" or cancellations in which the patient does not give our office at least 24 hour notice. We generally provide a complimentary reminder 24 hours prior to your appointment. However, it is YOUR responsibility to remember your appointment time/date and/or to call the office to confirm. If it is after or before regular business hours please leave a message.

Signature _____Date_____

Financial Agreement

For patients with insurance, all co-pays are to be paid at the time of service. For patients without insurance, you must make financial arrangements prior to scheduling (we may or may not require payment in full prior to treatments rendered). If you are unable to fulfill your financial responsibility we do reserve the right not to render services at the scheduled appointment. If you have questions about your financial responsibility please let us know prior to your scheduled appointment. Our office accepts cash, personal checks, money orders, and all major credit cards. Patients who have historically demonstrated good credit at our office may elect to be sent statements (net 30). However, balances on the account of more than 30 days are subject to a service charge of $25.00 per month AND a 20% APR finance charge.

Signature _____Date_____

Dental Material Fact Sheet:

This brochure, published in 2004 by the Dental Board of California, is designed to give patients a grasp of different dental materials. Please note that dental materials change frequently and that specific questions should be directed towards Dr. Nordstrom or Dr. Vizzolini prior to treatment.
I acknowledge that I have received the Dental Materials Fact Sheet.

Signature _____Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

This document is attached and also available at the front desk for your review during business hours.

I, _____, have received a copy of the William C. Vizzolini, DDS, INC and Morgan Nordstrom, DDS, Notice of Privacy Practices.

Signature _____Date_____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's name _____
Relationship to Patient _____

Insurance Assignment of Benefits and Billing

Our office will accept assignment of benefits from your insurance company with the provisions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- We will bill your insurance company as a courtesy with your consent as signed below.
- We require you pay the estimated portion not covered by your insurance company at the time we provide service to you.
- The portion that we estimate is only an estimate which could result in an additional amount due after benefits have been paid to our office. Insurance is ordinarily received within 30-45 days from the time of billing. If your insurance company has not made payment to our office within 60 days, you will be responsible for the entire balance at that time. At that point you will be responsible for seeking reimbursement from your insurance company if you choose to do so.
- We do not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- We will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation that your insurance company requests to sort out any confusion or questions that may arise. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and accept the terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to William C. Vizzolini DDS, INC and Morgan Nordstrom, DDS.

Signature _____Date_____

The BEST dental “insurance” consists of three things (in order of importance):

1) Good brushing and flossing multiple times per day by the dental patient
2) Good diet (limited carbohydrates and acidic foods).
3) Frequent dental exams with x-rays and professional cleanings at the intervals recommended for you by your dentist.

By catching and treating dental problems when they are SMALL, you will save a lot of $$$, time and teeth!