502-292-3272

OLDHAM COUNTY
family dentistry

oldhamcountyfamilydentistry@gmail.com

Thank you for choosing Oldham County Family Dentistry

As we are an appointment based practice, all appointments are very important to us. Out of respect for those patients who would like to be seen promptly at a time convenient for their busy lives, we have a cancellation policy. Please take a moment to read through our policy, then sign and date the bottom. We appreciate all of our patients, and confirmed appointments allow us to serve the needs of all our patients with the highest level of quality and care.

We have many methods of confirmation in order to remind you of your appointment date and time. We can text and email any working number or email address provided by you.

If we have not received a confirmation from you by one business day before your appointment, we will call all numbers provided in an effort to reach you personally. We will always leave a message. If we are unable to reach you the day before to confirm your appointment, we cannot guarantee the time will not be offered to another patient with urgent needs. So, if we leave a voicemail, please call us back.

We understand that sometimes things come up; so if you need to cancel or reschedule an appointment, all we ask is that you provide us with as much notice as possible and at least 24 hours notice so that we may have time to accommodate another patient.

CANCELLATION AND "NO SHOW" POLICY

If a patient has:
- 3 "No Show" appointments after scheduling them or
- Has frequently cancelled the appointment with less than 24-hour notice

Then:

The patient will be placed on a "same day only" appointment list. This will require the patient to call us on the day they want to come in for an appointment; and if there is an opening that day, we will be able to schedule the patient.

We value and appreciate all of our patients, and we want to be able to provide them with the oral care they need as promptly as possible. Please ask us if you have any questions or concerns.

Printed Name	Signature	Date

FINANCIAL POLICY

Thank you for choosing Oldham County Family Dentistry as your dental care provider. In order to make financial arrangements for your treatment, we offer several flexible payment options. We accept cash, checks, all major credit cards, as well as 3rd party financing. For unaccompanied minors, we ask that you make financial arrangements prior to the day of their appointment.

DENTAL INSURANCE

We are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you, we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and your portion of the cost of treatment, which is due at time of service. Since this is an estimate only, you may have an additional balance due, or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your insurance coverage.

MISSED APPOINTMENTS

Please help us serve you and all of our patients better by keeping your scheduled appointments. If it necessary for you to reschedule your appointment, please give us a 24-hour notice in order to avoid a $25 fee.

PLEASE TURN OVER

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our privacy practices comply with Omnibus 2013

Oldham County Family Dentistry keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. This notice is a detailed explanation of how we may use your protected health information and your rights to inspect and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this notice. Our privacy practices comply with Omnibus 2013.

You may refuse to sign this acknowledgement

I have had full opportunity to read and consider the contents of the office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

Print Name _____ Signature _____ Date _____

CONSENT TO USE IMAGE FORMS

We strive to perform the best dentistry possible at Oldham County Family Dentistry, whether in the form of restorative, esthetic, or preventative. We take pride in our training and skills, and with this will sometimes take pictures of work that we have done. These allow us to not only view the quality of work we have done in the office, but also allows for educational experiences of office personnel and patients. Your permission will always be asked before we take an image, and you always have the right to refuse. I understand I am giving my permission to use my images in order for the office to educate and promote.

Print Name _____ Signature _____ Date _____

CONSENT FOR TREATMENT

Patient Name: _____

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I permit the recommended diagnostic procedures to be completed.

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of treatment.

I consent to the injection and administration of local anesthetics. I understand that there is an element of risk with the injection of any injectable agent. These risks include, but are not limited to: adverse drug reactions, allergic reactions, cardiac arrest, tachycardia, swelling, bruising, pain, transient or permanent nerve damage, asthmatic reactions, needle tract infection, or other unspecified injuries.

I wish to proceed with treatment

Signature _____ Date _____

I refused to proceed with treatment

Signature _____ Date _____