Castillo
Family Dentistry

Patient Information

Insurance Information

Continue on other side

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Privacy Policies

HIPPA PRIVACY ACT states that no patient information may be shared with any person or office without the written permission of the Patient/Guardian of a minor child.

I understand this policy and have been offered an opportunity to ask questions pertaining to it.

Patient Name:_____

Address:_____

_____

Phone:_____

Patient/Guardian/Parent Signature:

_____

Please list any person or proffesional office that we may discuss your dental treatment with below. **Parents** of children and **spouses** must be listed if you want them to have your consent.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Continue on other side

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Office Policies

I, the undersigned, hereby authorize Dr. Castillo, and/or his designated employees to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Castillo to make a thorough diagnosis of the patient's dental needs. I also authorize the performance of any and all treatment, medication and therapy based on those needs. I further authorize and consent that Dr. Castillo choose and employ such assistance as he deems appropriate. I understand that the use of anesthetic agents embodies certain risks.

I give permission for the staff of Dr Castillo's office to discuss the appointment and treatment information on my voicemail, text message, and/or e-mail.

I understand that the responsibility of payment for dental services provided by this office for myself and/or my dependants is mine, due and payable at the time service are rendered, unless financial arrangements have been made in advance. I understand that my account will be debited $33 for any returned check. I understand that checks that have been returned for Insufficient Funds, if not paid within 10 days of notification, will be turned over to the Magistrate Court or Collection Agency where additional charges will be incurred.

I certify that I am covered by _____(Dental Insurance Provider)_____ and I assign directly to Dr. Castillo all insurance benefits, otherwise payable to me. I understand that I am reposible for the timely payment of my account whether or not my insurance pays. Billing problems, the result of incorrect information provided by me, will incure a $3.00 update/rebilling fee per claim. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

I understand that my insurance carrier may process the actual bill for services. I understand that I am responsible for all costs of dental treatment. I promise to pay payment in full at each appointment. If I do not pay at least a portion of the new balance within 30 days of the monthly billing date, then I understand that my account can be sent to collection agency for further action. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding account.

I understand that if I wish to pre-pay for any services, then those services are considered completed, and no refund will be made if I change my mind regarding the services. A credit will be added to my account for future services instead.

I understand that appointments are considered confirmed at the time they are made. If for any reason I have to cancel my appointment, I understand that I must give atleast a 24 hour notice. If I fail to do so, then I may be subject to a $30 failed appointment fee.

I have read and understand this office's policy regarding payment and appointments.

Patient/Parent Signature: _____ Date: _____