Moeiz Koshki, D.D.S.

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310-395-1261 * drksohki@yahoo.com

OFFICE POLICIES

CANCELLATIONS/MISSED APPOINTMENTS: When you schedule an appointment at our office, time is reserved specifically for you and your individualized treatment. We value the time you are taking to see us, and we know you value the time this office dedicates to you. We utilize an automated system for reminders and confirmations that gives ample opportunity to make any necessary changes well in advance of your appointments. We require at least 24 hours notice (**1 business day**) for changes in appointments to avoid a fee. ANY appointments that are missed, cancelled or rescheduled without 24 hours notice will be charged a fee. No further appointments can be made until this fee has been paid.

For **any** appointment missed, cancelled or rescheduled without 24 hours notice in our **hygienists'** schedule, the fee will **be equal to the full value of the appointment, not to be less than $100.00. _____ INTIAL**

For **any** appointment missed, cancelled or rescheduled without 24 hours notice in Dr. Koshki's (or assigned Dentist) schedule, the fee will **be charged at $100 per hour, not to be less than $100.00. _____ INITIAL**

FORWARDING X-RAYS: It is required that you sign our authorization form to request that your x-rays be transferred to a subsequent dental provider. This office needs **48 hours** notice for such transfers. If we refer you to a specialist and they require an x-ray that we already have, no authorization or fee is required.

CONSENT FOR TREATMENT: By signing below, you hereby give this office permission to perform dental treatment for you or your dependent (s) as is necessary and/or desirable and to administer drugs and/or anesthetics as deemed advisable by Dr. Koshki and/or his assigned.

NOTICE OF PRIVACY PRACTICES, PATIENT ACKNOWLEDGEMENT & RECEIPT OF DENTAL MATERIALS FACT SHEET: By signing below, I acknowledge that I have received and understand this office's Notice of Privacy Practices. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If changes occur, the office will provide me with a revised Notice upon request. Also, by signing below, I acknowledge that I have received a copy of the Dental Materials Fact Sheet, as required by law.

PAYMENT: Payment is expected at the time of service unless prior financial arrangements have been made. If you have dental insurance, our staff will provide an estimate of your insurance benefits and your co-payment, ***which is due at the initial service appointment.*** This is an **estimate only.** Verification of your insurance benefits never guarantees payment and whatever charges occur are ultimately **your responsibility.** For your convenience, we accept VISA, MasterCard, Discover and American Express as well as cash and personal checks. Outside financing is also available through CareCredit and Springstone Financing. There will be a $35.00 fee for returned checks.

I ACKNOWLEDGE THAT ALL CHARGES INCURRED IN THIS OFFICE ARE MY RESPONSIBILITY. Should my insurance **for any reason** fail to pay for all charges billed, I agree to pay for services upon notification from this office. I understand that if my account remains unpaid by me for 30 days, it may be referred to an attorney or other agency for collection activity. Further, I agree to be responsible and pay for all costs incurred, including attorney's fees and 18% annual interest.

FOR THOSE WITH INSURANCE: I hereby authorize payment of the dental benefits otherwise payable to me directly to the office of Dr. Koshki.

_____
Patient Name

_____ ____/____/____
Patient Signature Date

Office Representative Signature: _____ ____/____/____
Date