



Moeiz Koshki, D.D.S. * Gail Sakamoto, D.D.S.

1227 Lincoln Blvd. Ste 201 * Santa Monica CA 90401 * 310-395-1261 * office@drkoshki.com

OFFICE POLICIES

CANCELLATIONS/MISSED APPOINTMENTS: When you reserve an appointment in our office, time is specifically set aside for you and your individualized treatment. We value the time you are taking to see us, and we know you value the time that our office dedicates to you. We utilize an automated system for reminders and confirmations that give ample opportunities to make any necessary changes well in advance of your reserved 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 hygienist's schedule, **the fee will be equal to the full value of the appointment, not to be less than \$100.00** **INITIAL.**

For any appointment missed, cancelled or rescheduled without 24 hours notice in the Doctor's schedule, **the fee will be charged at a rate of \$100 per hour, not to be less than \$100.00** **INITIAL.**

FORWARDING RECORDS (X-RAYS): In order for us to forward any requested records or x-rays from our office to any subsequent dental office, we require that you complete and sign our "Authorization to Transfer Records" form. **We require 48 hours notice for such transfers.** We do not charge for this service. No authorization is needed if this office has referred you to a dental specialist and they have requested your records or x-rays.

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

NOTICE OF PRIVACY PRACTICES, PATIENT ACKNOWLEDGMENT & 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 this form, I acknowledge that I have received a copy of the Dental Materials Fact Sheet, as required by law.

PAYMENT: Payment is due at the time of service (or as service is initiated in the case of multiple visit procedures) unless prior financial arrangements have been made with the Office Manager. If you have dental insurance, our staff will provide an **estimate** of your insurance benefits and your expected co-pay, **which is due at the time of service (or as service is initiated in the case of multiple visit procedures.) This is an estimate only.** Verification of your insurance benefits never guarantees payment and whatever charges you incur are **your responsibility**. Every effort is made by our office to get your insurance claims paid in a timely manner. **ANY CLAIM NOT PAID WITHIN 60 DAYS OF TREATMENT RENDERED BECOMES YOUR RESPONSIBILITY, and is due and payable by you.**

For your convenience, we accept VISA, MasterCard, Discover and American Express as well as debit cards, cash and personal checks for payment.

Outside financing is available for no-interest terms (if qualified) through CareCredit, a third-party credit card company. You may learn more about CareCredit or apply by visiting their site: www.CareCredit.com

I ACKNOWLEDGE THAT ALL CHARGES INCURRED IN THIS OFFICE ARE MY RESPONSIBILITY.

Should my insurance fail to pay their portion for any services performed in this office for any reason, I agree to pay such services upon notification from this office. I understand that if my account remains unpaid by me for 30 days after billing, it may be referred to an attorney or other entity/agency for collections processing. Further, I understand that I will be held responsible to pay for all costs incurred with collection activity, including attorney's fees and 18% annual interest.

FOR THOSE WITH DENTAL BENEFITS (INSURANCE):

I hereby authorize assignment of benefits to be paid directly to the office of Moeiz Koshki, D.D.S., Inc.

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| PATIENT NAME (PRINT) | PARENT OR GUARDIAN NAME (PRINT) |

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| PATIENT/GUARDIAN/PARENT SIGNATURE | DATE |

Office Representative: _____

Office Representative: _____
Date