GEORGE DRACOPOULOS D.D.S., INC.

OFFICE POLICIES

Please note that your co-payments are due at time of appointment. Crown, Bridge, and Denture co-pays are due at time of Impressions.
Payments are accepted in the form of cash, check or credit card.
There will be a $25.00 fee applied to all returned checks.

Cancellation policy: A 24 hr notice is required to cancel or reschedule an existing appointment to avoid a broken appt charge. Failure to show up for a scheduled appointment will result in a charge of $1.00 per minute of your appointment time.

HIPPA

Thank-you very much for taking time to review how we are carefully using your heath information. If you have any questions we would like to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by sighing below.
You may obtain a copy of our privacy notice by asking one of our front office staff members.

INSURANCE AGREEMENT

This is to inform all patients with insurance coverage that we verify insurance benefits prior to treating any patient. Once the patient is in our office and provides insurance information we do call to receive a break down of benefits. PLEASE keep in mind any coverage over the phone is NOT A GUARANTEE OF PAYMENT. Your co-payment is due at the time that services are rendered. Once we submit claims to your dental insurance, if they do not pay in full, you as the patient are responsible for any balance due on his or her account.
We will bill a maximum of 2 insurance companies'.
PLEASE READ AND SIGN this form stating that you understand the terms and conditions of this office. If you any questions please ask the front office staff to explain before signing this form. Thank-you.

Patient Name____________________________________

Signature of Responsible Party _____________________________________

Relation: _________________________

Date: _______________________________________

PERMIT FOR OPERATION UPON A MINOR

Patients Name _________________________
I hereby the parent (or Guardian) of said minor patient do hereby authorize the performance of dental services upon this patient, and to do whatever procedures that the judgment of the above named doctor may dictate during the operation. I do authorize and request administration of such anesthetic, or anesthetics, as may be deemed advisable by the doctor
Parent's Signature ____
Relationship____________