Permission Form

I hereby authorize and direct the dentist Dr. Jumana Ghorab, DDS and/or auxiliaries of her choice, to perform the following dental treatments or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventative hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Applications of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings/crowns).
D. Replacement of missing teeth with dental prostheses (bridges, partial, dentures, full dentures).
E. Removal (extractions of one or more teeth).
F. Treatment of diseased or injured oral tissue (hard and/or soft)

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me and that I will have an opportunity to ask questions regarding the treatment and the risks prior to beginning treatment.
3. I agree to the use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and the numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and check biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory answer, and I understand that I have the right to be provided answers to questions, which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: _____ Date: _____ Time: _____am/pm

Patient or Parent Signature: _____

This applies to patients over age 18 that are covered under their parents Insurance:

I hereby grant permission to Dr. Ghorab and staff to release information related to my health and/or dental treatment to my parents or legal guardian.

_____ _____

Signature: Date:

Office Guidelines

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

Financial Responsibility

1. Payments extended beyond thirty (30) days from the first billing will acquire interest at the rate of 1.5% per month of unpaid balance (18% annual rate).
2. There is a **$25.00** charge for all returned checks.
3. In the event of default, I promise to pay legal interest on the indebtedness, collection costs, and related attorney's fees.

Dental Insurance

We are happy to file the forms necessary to see that you receive full benefits of your coverage, however, we cannot guarantee any estimated coverage. You will pay the percentage of your responsibility as services are performed. Please keep in mind that we can only **estimate** your portion. If there is a difference after your insurance company has paid, it is your responsibility to pay the difference. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within 60 days from the date of treatment, you are responsible for payment at that time.

Payment Options: Cash, Check, Mastercard, Visa, American Express, Discover and CareCredit

We have set aside an appointment time specifically for you. If you are unable to make your scheduled time we ask that you cancel/re-schedule 24 hours in advance. If no advance notice is given we reserve the right to charge your account a **$50.00** fee.

If you understand and agree with all of the above guidelines, please sign your name below and we will accept your insurance assignment.

Patient's Name: _____Date: _____

Patient or Parent Signature: _____

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA)

(Please ask if you would like a copy)

I, _____ have read and understand the Privacy Policy Act.
Print Name:

_____ _____
Signature: Date: