Anna V. Durkin D.D.S., Inc.
2010 cassia rd stc 110
Carlsbad ca 92009

OFFICE POLICY

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. ***Please be aware that your initial visit may take up to two hours to complete due to insurance verification and necessary paperwork. I understand that all x-rays, study models, photographs, any forms and progress notes are Dr. Durkin's property and can not be removed from office.***

2. ***I consent to the treatment mutually agreed upon by me outlined in the treatment proposal. I also authorize and consent to unplanned treatment or treatment that was not on the outlined treatment proposal, due to unpredictable results in treatment and to use the appropriate medication and therapy indicated for such treatment.*** I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that no refund could be made after treatment is initiated. I understand that if patient or patient representattive terminates the treatment there is no refund for treatment that was already initiated.

3. ***If for any reason treatment is viewed as unsatisfactory or unsuccessful and a dispute arises that the signed patient is dissatisfied, the matter must be resolved by peer review of California Dental Association or arbitration.*** Arbitration cannot be initiated until the treatment has been completed or terminated by the doctor and the patient, involving treatment or any financial contract, the matter shall be settled by binding arbitration. The arbitration will be conducted according to the American Arbitration Association rules and regulations in force at the time of the occurrence of the dispute, grievance or controversy.

4. I understand that all responsibility of payment for dental services provided in this office for myself and for my dependents is mine, due and payable at the time the services are rendered by the agreed dates. I understand that a 1 ½% finance charge (18% APR) may be added to my account. The undersigned authorizes our office to bill your insurance for services rendered. Please be aware that some services may not be a covered benefit under your insurance plan***. If your insurance company does not pay us for services rendered, you will be responsible for any remaining balance.***

Patient Name: _____Date:_____

Patient/ Guardian Signature: _____