desert smiles
COSMETIC + RESTORATIVE DENTISTRY

Nathan P. Tenney, D.M.D.
P **(602) 978•1790** F **(602) 978•5211**
18275 N 59th Ave, Bldg C, Ste 114 – Glendale, AZ 85308

FINANCIAL AGREEMENT

Welcome! Thank you for choosing our office as your dental care provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health. It is our goal for patients to clearly understand their treatment plan, as well as their financial responsibility before treatment begins.

As a courtesy to you, we will gladly process your insurance claims. We understand the value of insurance and will gladly work with you to maximize your benefits. We are able to provide assistance in estimating your insurance benefits and filing your claims for you. We do not accept HMO or DMO policies, where they require you to stay within their network. All insurance benefits are payable to the dentist office unless specified by your insurance provider. As most insurance plans do not cover 100% of your treatment costs, we offer the following forms of payment here in our office.

- Visa, MasterCard, American Express, Discover, Cash or Check
- In addition, we also accept Care Credit, for those patients wishing to finance all or a portion of their treatment costs. This financing option often offers 0% interest for 6 or 12 months. You can log onto their website and prequalify for your treatment costs.
- Feel free to ask our office about in house payment options.
- If you do not have dental insurance, we kindly offer a 5% savings on your total amount due, if paid in full on the date services are rendered.

For treatment requiring significant chair time, a 50% deposit is required to reserve your appointment. Your deposit applies toward your scheduled treatment. If you cancel before treatment, your deposit will be refunded, less any lab fees.

We have a 48 hour cancellation policy. Please call us in the event you need to cancel or reschedule.

Name (Print): _____

Signed: _____ Date: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Privacy Notice Amendment

I have been given the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer my questions that I may have now, or in the future, regarding the use on my Personal Health Information. By signing this form I acknowledge that I have had the opportunity to read and discuss my rights.

Patient Name: ______________________________ Date: ____________________

Patient Signature: ____

- -

If I wish, I give Desert Smiles permission to discuss my medical and dental care and release records to the individuals/providers listed below:
Name of Individual/Provider Desert Smiles may release my records to: ____________________

- -

Photo Release Consent Form

__________ I authorize the use of my clinical x-rays, photographs, video and personal testimonials to be used by Desert Smiles for online and in house marketing purposes.

__________ I only authorize images of my mouth/teeth/x-rays, with no personal identifiers, to be used by Desert Smiles for online and in house marketing purposes.

Patient Signature: ______________________________ Date: ____________________