OCALA PERIODONTICS
& DENTAL IMPLANTS
JAMIE N. AMIR BDS, MS

Patient's Name:_____ Date of Birth_____

CONSENT FOR TREATMENT

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Ocala Periodontics & Dental Implants. These procedures may include, but are not limited to; examinations, scaling and root planing (deep cleanings), periodontal surgery, periodontal maintenance, restorations, periodontal treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

INITIALS_____

CANCELLATION POLICY

Ocala Periodontics & Dental Implants has a 24 hour cancellation/rescheduling policy. **If you miss your appointment or cancel/change your appointment with less than 24 hours notice, you may be charged a $50 cancellation fee.**

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Ocala Periodontics & Dental Implants.

INITIALS_____

PAYMENT POLICY

Payment for treatment is expected at the time of service. Our office accepts cash, checks, Visa, MasterCard, Discover, American Express, Care Credit and Lending Club Patient Solutions.

INITIALS_____

INSURANCE POLICY

Insurance claims will be filed on your behalf so that you will receive any reimbursement available directly from your insurance provider.

Insurance is an agreement between you and your insurance company. Lack of payment from an insurance company does not negate the patient's responsibility to pay for treatment rendered in good faith. Consequently, if a claim is denied by an insurance company, the cost of the treatment remains the patient's responsibility and is therefore non-refundable.

INITIALS_____

_____
Printed Name of Patient or Patient's Representative

_____ _____
Signature of Patient or Patient's Representative Date