Dr. Steven M. Goldy

Welcome and thank you for selecting our office to provide your dental services. The following is a **Statement of Informed Consent,** and an explanation of our general office policies. Please read it carefully and initial/sign where indicated.

This initial visit is either for an emergency or for a complete dental examination and evaluation. For an **Emergency** visit, the doctor will evaluate only the specific area of concern and treat the signs and/or symptoms accordingly.

For an initial complete dental examination and evaluation, I authorize the doctor and his/her auxiliaries to take any dental x-rays they feel necessary. I understand that the doctor may not be able to perform any treatment without these x-rays. After the initial examination and diagnosis, the doctor will inform me of his/her recommendation for treatment, as well as any options for such treatment. I understand that this initial visit **Does not include a prophylaxis (cleaning).** However, the doctor or hygienist may provide this service, if time permits.

INITIAL _____

This is a general dentistry office and we provide a multitude of a general dentistry services including but not limited to: simple fillings (restorations), crowns, bridges, dentures, root canal therapy, oral surgery, simple periodontics, implant, prosthodontics, and aesthetic dentistry. I understand that each of these contains inherent risks and ramifications: some of which will be explained to me at the time of such services are rendered. I understand that dentistry is not an exact science therefore, reputable practitioners cannot guarantee treatment and results. I acknowledge that no guarantee has been made by anyone regarding dental treatment. **I acknowledge these facts and give my consent for general dentistry.**

INITIAL_____

I understand that during treatment; it may be necessary to change or add procedures because of conditions found that were not apparent during the initial examination; the most common being the need for a root canal therapy following routine restorative treatment. I give my permission for the doctor to make changes as necessary and I understand that such changes will be explained to me at the time of their discovery.

I understand that any dental insurance that I have, may have co-payments (patient share) for many dental procedures. I understand that I will be informed of such co-payments and that **I am fully responsible for all fees due and payable in full at the time services are rendered.**

INITIAL_____

I have read and agree to the aforementioned policies

PATIENT SIGNATURE _____ **DATE** _____

DR. SIGNATURE _____ **DATE** _____

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients in a consistent and organized fashion. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient; unless we are given adequate time to attempt to schedule another patient for that designated appointment time.

Our policy is as follows:

We require that you give our office **48 hours notice (2 business days not including Friday, Saturday or Sunday when our office is closed)** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **a fee of $95.00 (for a 45 min appt) or $100.00 per hour (for appts over an hour)** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled until this matter is resolved.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and a cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice

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Signature of Patient Date

Steven Goldy DDS 416 N Bedford Dr Ste 102., Beverly Hills, Ca 90210 (310)550-1511