Renfroe Family Dental
Derek Renfroe, DMD, FICOI, FAGD
VETERAN OWNED BUSINESS

Dr. Derek Renfroe
311 Spring Street, Dover, TN 37058
931 232 7105, 931 232 2242

PATIENT CONSENT

Clinical

1. I authorize Renfroe Family Dental and/or it's providers to perform all recommended treatment on me and/or my dependents if I am the parent/guardian of the patient named below.
2. I authorize Renfroe Family Dental and/or it's providers to take radiographs, study models, photos, and/or other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I will not refuse diagnostics, including minimally necessary radiographs. I understand treatment cannot be completed without proper diagnostics and refusal of diagnostics will result in dismissal from the practice without exception. I authorize that such Diagnostic Material(s) may be released to third-party payors and/or other health professionals. I also understand refusal to accept and complete treatment for diagnosed disease such as periodontitis will result in dismissal from the practice. There will be no exceptions to these policies.
3. I authorize the use of anesthetics, sedatives, and other medication as needed, and am fully aware that using anesthetic agents involves certain risks, including by not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR is automatically added to my account if my balance is 30 days or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees, court costs, etc.
5. I understand the attendance policy requires a minimum of 24 hour notice to cancel or change my appointment otherwise a $50 Broken Appointment Fee will be charged for the first missed appointment or late cancellation by me. The second missed appointment will incur a $75 fee and the third missed appointment will result in a $100 fee as well as dismissal from the practice.
6. Payment is due at the time services are rendered. A $3 processing fee will be applied to statements that are 60 days past due. I understand that credit card fees may be applied if using a credit card.

Insurance

7. I authorize Renfroe Family Dental and/or it's providers and/or staff to release to staff, hospitals, health care service plans, insurance companies, self-insurers and/or their representatives, any and all information, records, and/or other Diagnostic Material(s) related to my medical and/or dental history, services rendered, and/or recommended treatment. This list is not all-inclusive and other items may be included in this consent.
8. I authorize Renfroe Family Dental and/or it's staff or other representatives to submit claims for payment for services rendered and/or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file." I hereby assign to the Renfroe Family Dental and/or it's providers the insurance benefits providing this assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this document in it's entirety and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Phone _____ Email _____

_____ _____

Patient Parent/ Guardian Signature:

This notice supersedes and replaces any previous notices and/or policies. Changes may occur without notice. 2/7/2017