SILVERWOLF
DENTAL

Jason Wareham, DMD
Family & Cosmetic Dentistry

PLEASE READ CAREFULLY

We would like to take this opportunity thank you for choosing SilverWolf Dental as your dental health care provider.

Appointments:
We extend our appreciation by respecting you and your valuable time. We strive to keep your wait after check-in to a minimum. We ask that in return, you respect our time.
If you are more than 15 minutes late for your reserved time, you may be asked to reschedule.
A 24 business hours notice of cancellation must be given in order to avoid a $100 missed appointment fee.
I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

Emergency Care:
If you or your family members have an accident or need assistance after regular office hours, call our main number and listen on how to contact one of the doctors. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. Care received during non-office hours is subject to an additional charge.

Payments:
We accept cash, personal checks, money orders, debit cards and all major credit cards. Payment is due at the time of service. A $25.00 processing fee will be added to your account for any returned checks. If payment arrangements are made, a $25.00 late fee will be added to your account if payment is not made by the due date each month.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

Collections & Interest:
I agree to pay interest at the rate of 1.5% (18% annually) on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by fax or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have had the opportunity to see and read the Privacy Policies of this office. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein. We again thank you for your patronage and cooperation.

I UNDERSTAND AND AGREE TO ABIDE BY THE TERMS OF THIS OFFICE.

Signature:_____ Date:_____