



Clarke V. Filippi, DDS, Inc.

Specialist In Periodontology • Implants
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Patient Name: _____

Welcome to our practice. We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best possible dental and periodontal care for our patients.

Please read the following statements. **The patient or legal guardian must agree and sign.**

General Release

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I further authorize and consent that the doctor may consult with my physician or other health care providers regarding my periodontal treatment. I also authorize the doctor to perform any form of treatment, medication, and/or therapy that may be indicated. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed.

Financial Responsibilities

Part of our commitment to patient care is to provide you with information about your dental needs and treatment, including the estimated costs of your quality care. Our fees are individually based on the time, severity and difficulty of your specialty treatment. **Payment not covered by your insurance is expected at the time of service.** We accept cash, check, ATM, and credit card payments. A \$25.00 fee is charged on all returned checks. A 1.5% service charge will be assessed on all accounts not settled within 90 days of service.

I understand that I am responsible for any payment due for services that I have received. In addition to the portion of the services not covered by my insurance carrier, I am responsible for any outstanding balance after the insurance carrier has been estimated and / or billed. I also understand that payment not covered by my insurance is expected at the time of service. After 90 days, I understand that I will become responsible for all unpaid outstanding insurance claims. If the Clarke V. Filippi, DDS, Inc. Periodontal Practice is subsequently paid by the insurance carrier I will be reimbursed.

Finally, I understand that the Clarke V. Filippi, DDS, Inc. Periodontal Practice reserves a specific time for me on their appointment schedule and that cancelling an appointment without 24 hour notice or not showing to an appointment does not allow time for that vacancy to be filled. Therefore, I am hereby notified that this office reserves the right to charge for missed appointments or those cancelled without 24 hour notice.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____