PAULETTE S. BASS, D.D.S.
OFFICE GUIDELINE FORM

__ Patient Rights Information was reviewed with me and I have been given:
a copy of Patients privacy rights and OSHA compliance pamphlet.

FINANCIAL RESPONSIBILITY

__I understand that there are fees for the services provided by Dr. Paulette Bass, and I have been informed of those fees.

__I understand that if I have insurance that covers this treatment, Dr. Bass will bill my insurance as a convenience to me, but I agree that I am fully responsible for paying any fee not paid by my insurance.

__I agree that any fees, co-payments or deductibles are to be paid at the time of my appointment unless other arrangements have been made with the business administrator.

__I agree to provide all documentation necessary to assure payment by my insurance carrier. I understand that if I fail to provide such records, I will be responsible for all fees.

__I will inform Dr. Bass of any change in my insurance.

__I authorize Dr. Bass to communicate with my health insurance company and agents regarding coverage which may be applicable to services received by myself or my dependents. I further authorize Dr. Bass to release information to my insurance company or its designated agents concerning services rendered and to forward statements of charges and payments to my home.

__I understand that if I fail to keep a scheduled appointment or do not provide at least 48 hours notice if I need to cancel or reschedule an appointment, I may be charged a $40.00 "No Show" fee.

__If my account is delinquent-I give authorization to check credit history.

TREATMENT AUTHORIZATION

__The services that I receive from Dr. Bass have been explained to my satisfaction. The purpose of treatment and any related risks, benefits and alternatives to treatment has also been explained. I understand that the results of such treatment cannot be guaranteed.

__I here by give voluntary consent for treatment.

__I authorize Dr. Bass to mail general information to my home address about services and programs available at her office and to leave phone messages for appointment reminders.

__I understand that I may terminate this consent at any time in writing.

Signature of Patient/Responsible Party

Witnessed by