Sonja L Maggard, DMD
Family, Cosmetic, & Implant Dentistry

121 Prosperous Place, Suite 12B
Lexington, KY 40509
(859) 263-1888

Office Policy and Consent Form

Please remember, we are happy to serve you in a comfortable and professional atmosphere. We do care, and we will provide you with the best quality of dental care available.

INSURANCE AND PAYMENT POLICIES

- Fees for Service at our office will be requested at the time of your visit.
- For Patients With Dental Insurance: We ask that you pay your deductible at your initial visit, and that your estimated portion be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances not covered by insurance benefits are your responsibility.
- All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatments.
- Please note for your convenience, we do accept VISA, MasterCard, Discover, American Express as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we do require a 72-hour notice. Noncompliance will result in a broken appointment charge of $35.00 or more, or no reappointment.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child under 18 years old is responsible to us for all fees incurred.
- A 1.5% finance charge will be assessed monthly on all overdue balances.
- If you have any questions regarding our policies and procedures, feel free to discuss them with us.

CONSENT TO TREAT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform diagnostic x-rays and treatment procedures, including local anesthesia and sedation deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment.

By law, Dr. Maggard must have x-rays before any dental treatment is rendered.

*Patient/Parent/Guardian Signature:*_____ *Date:*____/____/_____

If patient is child, please print child's name_____