Welcome To Our Dental Office!

We are glad you chose Dental Worx. Dr. Cristina Sosa Anderson and her caring staff eagerly await the opportunity to care for your needs. Our practice is dedicated to providing quality preventive, restorative, and cosmetic care for the entire family. Our goal is to build life-long relationships with our patients and their families. We hope that your visits with us will be educational and conducive to accomplishing the dental health you desire. We are here to serve you in all your dental care needs.

Insurance: To avoid misunderstandings regarding dental insurance, we wish our patients to know all professional services rendered are charged directly to the patient. We will file all necessary forms or reports to your insurance company. We do not render our services on the basis the insurance companies will pay our fees. Patient will be held responsible for any fees the insurance company does not cover.

Payment Policy: Payment for all services is due at the time services are rendered. Patient is responsible for balance on account and any account 120 days past due will be turned over to a collection agency as provided by law and will be assessed a $30.00 collection service fee. All returned checks will be assessed a $30.00 NSF fee in addition to any other bank fees.

Cancellation Policy: If you are unable to keep your appointment please let us know 24-hours in advance so that we may schedule another patient and reschedule your appointment. Appointments not confirmed a day before by 1:00pm will be cancelled.

Missed Appointment Policy: After 3 missed appointments Dr. Anderson reserves the right to terminate the Doctor-Patient relationship.

Consent to treatment: I authorize Dr. Cristina Sosa Anderson to perform procedures including but not limited to prophylaxis (simple cleaning), taking radiographs or photographs, administering local anesthetic and/or medications, performing cosmetic dentistry, restoring (filling) teeth, and using nitrous oxide (if needed to help provide adequate dental care,) and other procedures she may deem necessary for my care.

My signature indicates that I consent to treatment and accept the policies of Dr. Cristina Sosa Anderson. I the undersigned, have insurance with _____ and assign directly to Dr. Cristina Sosa Anderson all benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Cristina Sosa Anderson to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions (manual or electronic.)

_____ _____

Patient signature (Parent if patient a minor) Date

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Acknowledgement of Receipt and Authorization

Dr. Cristina Sosa Anderson may release information to other entities or health care providers, for treatment, payment of services, and for health care operations as described in the **Notice of Privacy Practices.** Dr. Sosa Anderson has prepared this document in order to help you understand our policies in regard to the use and disclosure of your personal health information. I have been given the opportunity to review and receive a copy of the Notice of Privacy Practices.

_____ _____

Patients signature (parent if patient a minor) Date

_____ _____ _____

Print patient's name Date of Birth of patient Print parent's name (if patient a minor)