Peter Arsenault D.M.D.

If you have Dental Insurance:
The office staff will gladly complete the appropriate insurance forms and as a courtesy, will submit the forms to your insurance carrier. Once submitted, your insurance carrier, not our office, determines what they will cover on any dental procedure according to your insurance contract. Please check your carrier regarding your dental coverage and benefits.

Estimated patient co-payments are expected at the time of service unless other arrangements have been discussed.

Minors (Under the age of 18) must be accompanied by parent or legal guardian.
In the case that a parent/ legal guardian is unable to accompany the minor, **a written signed consent for treatment is mandatory**. We do not give out personal information except to the legal guardians or parents of minors.

Cancelled and Broken Appointments:
THERE WILL BE A 50.00 FEE FOR ALL MISSED APPOINTMENTS. THIS FEE MUST BE SATISFIED PRIOR TO BEING RE-APPOINTED IN OUR OFFICE. OUR POLICY IS A MINUMUM OF 48 HOURS NOTICE.

Premedication:

If you require premedication prior to your dental visits do you give our office permission to leave a message on your contact numbers or email to confirm premedication prior to your dental visits.

Initial:_____

Notice of Privacy Practice & Dental Materials Fact Sheet
Our office is in compliance with the Federal "Health Insurance Portability and Privacy Accountability Act (HIPAA).
This act allows us to relay limited information to any person of your household when we need to reach you. If you do not want us to speak with certain persons in your household or if you have any other restrictions, you must request them in writing.
I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain a most current copy of this notice.
I have had the opportunity to review the dental materials fact sheet issued by the FDA in 2002. A copy is available upon request.

INSURANCE AUTHORIZATION-SIGNATURE ON FILE & HIPAA ACKNOWLEDGEMENT, DENTAL MATERIALS FACT SHEET

I have read and understand all the terms mentioned above, and agree to its content.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to accept responsibility for payment of all services rendered on my behalf, or the behalf of my dependants. Further your signature authorizes Peter Arsenault D.M.D. to release private health information about you/dependants necessary to provide treatment, process claims for payment and other health care operations. I herein authorize payment of dental benefits to the Provider when an assigned claim is filed.

Signed_____Date:_____