Robert D. Hays, D.D.S.
Coventry Square
8035 Madison Avenue, Suite D-1
Citrus Heights, California 95610-7949
(916) 961-0163

Information Regarding Our Practice

Our Guarantee: We are proud to guarantee our work. We give a five year guarantee on all porcelain crowns and a two year guarantee on fillings received in our office. We extend this guarantee to our patients that complete all recommended treatment and keep all recommended hygiene and restorative appointments.

Your Visits Will Include Your Options For:

- Quality time with Doctor and Team
- Optimal tooth repair with the latest techniques and materials
- Digital X-rays- eliminating hazardous waste and up to 75% less radiation.

Dental Insurance: We are happy to file the forms necessary to see that you receive the optimal benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all of our patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits. Due to the fact that there are hundreds of different plans, it is not our responsibility to know your coverage.

Emergencies: Dental emergencies arise from time to time. When they do, please call our office immediately. We are equipped to take all before and after hours phone calls and return your call as soon as possible.

Appointments: We recognize the value of your time. We will do our very best to see you as promptly as possible. If there are any delays in your appointment time, our team will let you know right away. It is important that you come to your appointment on the scheduled time. If your schedule requires that you must leave your appointment at a certain time please make sure to communicate that to us in advance and we will do our very best to make it happen.

Cancellations or Broken Appointments: We are able to extend a "no charge" fee to our patients who give us 48 hours notice if unable to keep their scheduled appointment. A charge of $50.00 to $100.00 will be made per patient for each appointment that is not kept or not given adequate notice.

Patient Signature: _____ Date: _____

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. There rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g my insurance company)
- The day-to-day healthcare operations of your practice

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 the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20_____

Print Patient Name: _____

Signature: _____