Practice Consent

Thank you for choosing the practice of **Buckenheimer and Bulnes, DMD, PA.** We are dedicated to provide excellent comprehensive dental care that is personalized in a gentle, caring environment with compassion, integrity and respect.

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, limited orthodontics, radiography and cosmetic procedures.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____
Patient or Guardian Name

_____ _____
Signature Date

3906 West Neptune Street Tampa, FL 3362 . 813.259.9000

Office Policies

Payment Options:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- NO INTEREST Payment Plans from **CareCredit-Apply online at Carecredit.com**
- Buckenheimer and Bulnes, DMD, PA charges $35.00 for returned checks.

Please note:

- All fees for treatment are the patient's or the guardian's responsibility.
- Buckenheimer and Bulnes, DMD, PA requires payment prior to the completion of your treatment.

Appointments

We require 24-hour notice to cancel a scheduled appointment. If 24- hour notice is not given the following action will be taken:

- **1st broken appointment-warning and reminder of the cancellation policy.**
- **2nd broken appointment-charge of 50% of the scheduled treatment.**
- **3rd broken appointment-dismissal from the practice-records will be forwarded to your provider of choice.**

_____
Patient or Guardian Name

_____ _____
Signature Date

Insurance Policies and Electronic Authorization

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to Dr_____ all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services.
I am responsible for the full cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

Please note:
Buckenheimer and Bulnes D.M.D. P.A. will gladly submit any treatment to the patient's insurance carrier. It is vital for you to understand your specific insurance policy, the benefits and the limitations of your plan.

We will resubmit any open claim a second time after 45 days. All dental claims will be closed upon 60 days and the patient will be responsible for payment.

Buckenheimer and Bulnes D.M.D., P.A. will not request assignment of benefits on claims for Medicare plans or patients with double insurance coverage. Patients will be responsible for payment at the time of treatment.

All balance billing will be handled through our text messaging system Weave, therefore, Electronic Authorization (text messaging) consent is required.

Electronic Authorization

Your health care is important to us. In order to provide you with the best possible care, we occasionally send convenient electronic messages to our patients about their health care, products and services we offer and account information.
By providing your email address and or cell number, you are consenting to receive electronic messages for reasons stated in the above paragraph.

Email Address_____ Cell Phone_____

_____
Patient and Guardian Name

_____ _____
Signature Date

3906 West Neptune Street Tampa, FL 33629 . 813.259.9000

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Buckenhiemer and Bulnes DMD PA, this ___ day of _____, 20___. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please Print Your Name

_____
Please Sign Your Name

If you are the legal representative of the patient, please print the patients' name and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Christopher M. Bulnes DMD.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's signature on this acknowledgement but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
The patient was unable to sign because	____
Other (please describe)	____

_____
Signature of Privacy Officer