Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

Patient Name: ____ Date: _______________

Please Read Thoroughly and Initial Each of the Following Office Policies:

____ **Cancellation Policy:**

I understand that I am to give a minimum of two days (48 hours) notice for cancelling or rescheduling any appointment. Failure to do so will result in charges for the time you reserved. This fee will be 20% (minimum $45.00) of the total cost of treatment agreed upon and scheduled.

____ **Refund Policy:**

I understand that a 10% fee will be charged for the refund of any payments and/or financial arrangements that I make in the event I decline treatment that I have already paid/scheduled/arranged for.

____ **Treatment to be Done:**

I understand that I will be receiving an examination that includes a sufficient number of dental x-rays, and any additional appropriate diagnostic procedures necessary to complete my examination and treatment plan thoroughly. I also understand that any necessary referrals to a specialist are entirely separate from my exam and/or treatment at this facility and are my financial responsibility.

____ **Drugs and Medications:**

I understand that antibiotics, analgesics and other medication can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction.) I understand that it is my responsibility to disclose my health history and to inform my dentist of any known allergies to avoid possible adverse reactions.

____ **Local Anesthetics:**

The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate (which will return to normal). Common complications that can occur from local anesthetic include but are not limited to: pain, swelling, and bruising of the treated area. More severe symptoms may include, but are not limited to: numbness that lasts longer than 1 day, and in rare cases is permanent, abnormal sensations in the face, mouth, tongue, cheek and surrounding areas, transient blindness, and even death.

____ **Changes in Treatment Plan:**

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working in/on a diseased and/or other wise compromised tooth. I understand that not all conditions can be seen in x-rays or before the start of a procedure. I give my permission and request my dentist to make any and all changes and additions to treatment as he/she deems necessary during the course of my treatment.

____ **Financial Policy:**

I understand that Insurance is a contract between me and my insurance company. Infinity Dental file's insurance claims as a courtesy to patients. Should my insurance company's benefit be accepted as a form of payment all final costs are my sole responsibility. I further understand that while Infinity Dental does their best to provide accurate estimates of my insurance benefit amount, there is NO guarantee of benefits and I am responsible for any and all final costs. I understand that I am responsible for the timely payment of my account. I acknowledge and agree to pay reasonable collection fees, attorney fees, and court costs incurred during the collection of my overdue account.

X____ Date: ___________________

Patient/Guardian Signature