

Advanced Perio Endo eXperts

1243 E Spruce Ave, Fresno CA 93720 (559)436-8101

Welcome to our practice. Each member of our staff is proud to be a part of a team with a primary mission of providing the finest comprehensive periodontal and endodontic care. After examination and diagnosis, Dr. Jett and/or Dr. Newman will advise you of our treatment plan/options for your case.

NOTICE OF PRIVACY PRACTICE (HIPAA) AND DENTAL MATERIAL FACT SHEET: I consent to the release of health information to family members indicated as a responsible party on the introduction sheet, insurance plans or other entities to carry out treatment, payment activities and healthcare options. I consent for Dr. Jett and/or Dr. Newman to take photos and document my case throughout treatment to possibly use for presentations. I acknowledge the use of text/email Advanced Perio Endo eXperts uses to communicate may have risk of privacy issues. I acknowledge the **Notice of Privacy Practice** and the **Dental Material Fact Sheet** is posted and can be made available to me either in the office or online. I have been encouraged to read it and I may request a copy at any time.

NEW PATIENT ACKNOWLEDGEMENT: After a thorough consultation with Dr. Jett and/or Dr. Newman, my disease/condition will be explained to me and I will be made aware of the risks, benefits and alternatives of treatment. I will be informed of the risks and consequences of not following through with treatment and it is my responsibility to make an informed decision regarding pursuing Dr. Jett and/or Dr. Newman's recommendations for my case. Dr. Jett and/or Dr. Newman will strive for the best possible outcome and address any concerns in the consultation.

FINANCIAL POLICY: Our practice is committed to providing the best treatment for our patients and we strive to charge what is usual and customary for our area. I am responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates or re-imbusement. I give Advanced Perio Endo eXperts consent to use my contact information provided for calling/voice messaging/texting/email purposes for appointments, insurance, and collections with account balances. I may withdraw from communication at any time. Personal checks, cash, and major credit cards are accepted. We are pleased to offer both Denefits and CareCredit® as extended payment options. We will gladly give you details on how to apply.

Print Patient Name: _____

Signature: _____ Date: _____

The patient or nearest relative in the case of a minor or when the patient is physically or mentally incompetent must sign authorization.