Skyview Dental Patient Consent

As a patient at Skyview Dental, I acknowledge that I am aware of all of the following:

All procedures to be performed, as well as possible known risks and complications and all possible alternative treatments and their costs, will be explained to me by the Dentist or his designate. I hereby consent to those procedures. I am aware that the procedure may require local anesthetic and I hereby consent to the administration of such. I am also aware that during the performance of any treatment, **unforeseen circumstances may be revealed that could necessitate the performance of an additional or alternate procedure.** I will assume responsibility for any additional fees/balances that may incur from any necessary additional or alternate treatment.

Alberta does have a recommended standard fee guide which was implemented as of January 1st, 2018 by the Alberta Dental Association. However, dentists still can set their own fees according to their own individual practice. Materials, time, supplies/equipment and staffing are all taken into consideration when fees are set.

As a courtesy to patients, Skyview Dental does accept all forms of dental insurance. Skyview Dental will also direct bill all insurance companies (as long as the insurance company/policy allows for it). Therefore, patients will only be **responsible for the portion of their balance that is NOT covered by insurance.**

As a patient at Skyview Dental, I also acknowledge that should I have Dental Insurance coverage, **it is my responsibility to know and understand my insurance policy(s).** This includes such information as coverage maximums, deductibles, and my benefit year. Should be insurance coverage change, it is my responsibility to inform Skyview Dental of any changes.

Skyview Dental does have a cancellation policy in effect. Should I need to cancel or reschedule an appointment, **I must provide a full 48 hours' notice**, or there will be a **$50 fee** automatically applied to my account that must be paid before any further treatment can be completed.

Skyview Dental will not disclose any personal information obtained from any patient without patient/guardian consent unless required by law to do so.

I, (please print full name) _____ acknowledge that I have read and consent to all of the information provided above.

Signature of Patient (or guardian if under 18) _____

Date _____