Infinity Dental
Douglas P. Sanchez, DMD.
8940 W. Tropicana Ave.
Las Vegas, NV. 89147

Patient Name: _____ Date: _____

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

____ **Cancellation Policy**:
We require a MINIMUM of **48 business 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 a 20% (minimum $45.00) of the total cost of treatment agreed upon and scheduled.

____ **Requiring Pre-Payment:**
Patients who have failed (or cancelled without 48 hours) will be required to pre-pay in order to schedule future appointments. 20% of co-pays will be due upon scheduling in order to hold appointment times. Failure to show for a pre-paid appointment may result in the loss of down-payment.

____ **Refund Policy:**
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:**
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 medical conditions and/or allergies in order to avoid possible adverse reactions.

____ **Local Anesthetics:**
Local anesthetics 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