Beatriz Galofre DDS
720 Sunrise Ave. Suite 120A Roseville, CA 95661

Patient Registration

Acknowledgement & Consent

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my, or my dependent's dental needs.
2. I give consent to the doctor's or designated staff's use and disclosure of any oral, written and/or electronic health records that are individually identifiable as mine, or my dependent's for the purpose of carrying out my treatment, payment and health care. I hereby authorize the office e of Beatriz Galofre DDS to share all pertinent health information and records with referring doctors when conditions require. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
3. I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for the services rendered, directly to Beatriz Galofre DDS. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Beatriz Galofre DDS.
4. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand the either a12 % late charge (18%APR) or a t$15 last charge per late payment may be added to my account. I further agree to inform Beatriz Galofre DDS of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize Beatriz Galofre DDS to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.
5. I hereby acknowledge the use by Beatriz Galofre DDS of a 24 hours cancellation policy. Failure to cancel, reschedule less than 24 hours in advance or show up promptly for my appt. will result in a $50 fee. It is at the complete discretion of Beatriz Galofre DDS to waive such fee. Initials _____

Patient Signature_____ Date_____

Parent/Responsible party signature _____

Relationship to Patient_____

Witness_____