Anne Norris Ozer, DDS
Steven W. Ozer, DDS
451 Manhattan Beach Blvd, Suite C232
Manhattan Beach, CA 90266

Consent for Treatment

I hereby authorize Dr. Norris, Dr. Ozer or their designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of (name of patient)_____'s dental needs. Upon such diagnosis, I authorize Dr. Norris and/ or Dr. Ozer to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. _____ (Initial)

I give consent to Dr. Norris, Dr. Ozer, and/ or their designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. 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 upon request. _____ (Initial)

Insurance Patients

Beach Teeth and our doctors are Out of Network Providers for all PPO insurance policies, excluding Delta Premier. The office is happy to bill your PPO insurance; however, deductibles and co-pays may vary from policy to policy. Your deductibles and estimated co-payments will be due at the time of service. If you need clarification or have any questions regarding these matters, please ask one of our front desk staff members for their assistance. _____ (Initial)

Cancellation Policy

I understand that **a $70 cancellation fee** will be applied to my account for any hygiene appointments that are missed or cancelled with less than 24 hours notice. A minimum **cancellation fee of $125** will be applied for diagnostic, restorative or cosmetic appointments that are missed or cancelled with less than 24 hours notice. _____ (Initial)

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made and insurance is applied. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. _____ (Initial)

Acknowledgement of Receipt of Notice Of Privacy Practices

I have received a copy of the office's Notice of Privacy Practices. _____ (Initial)

Patient's Signature_____ Date_____