AA

Afsoun Asgharzadeh, DDS
2021 Santa Monica Blvd, Suite 704-E, Santa Monica, CA 90404
(310) 829-4322 | afsounasgharzadehdds@gmail.com | www.afsounasgharzadehdds.com

Financial Policy & Consent

Patient name

Date of birth (MM/DD/YYYY)

Thank you for choosing our office. We want you to understand your costs before treatment begins. Please read each section, initial it, and sign below. Ask us about anything that is unclear.

Dental insurance (PPO)

We accept all PPO dental insurance plans. As a courtesy, we verify your benefits and file claims for you. Insurance estimates are not a guarantee of payment; your plan decides what it will pay. You are responsible for your deductible, co-insurance, any amount over your annual maximum, and services your plan doesn't cover.

Initials

Payment

We accept cash and major credit cards. Your estimated portion is due at the time of service. You'll receive a cost estimate before any treatment, and we'll review it with you before starting larger treatment.

Initials

24-hour cancellation policy

Your appointment time is reserved just for you. If you need to cancel or reschedule, please call (310) 829-4322 at least 24 hours in advance so we can offer the time to another patient. Repeated late cancellations or missed appointments may limit our ability to reserve future appointments in advance.

Initials

Minors

The parent or guardian who brings a minor to the appointment is responsible for payment at the time of service, and a parent or legal guardian must consent to the child's treatment.

Initials

Consent to examination and treatment

I consent to a dental examination, X-rays, cleaning and other diagnostic and preventive procedures that Dr. Asgharzadeh considers necessary, including local anesthesia when needed. Before any further treatment, the recommended care, its benefits, risks, alternatives and costs will be explained to me, and I may ask questions and accept or decline it. I understand that dentistry is not an exact science and that no specific result can be guaranteed.

Initials

Signature

I have read and understand this financial policy and consent, and I agree to its terms.

Patient (or parent/guardian) signature (type your name, or sign on paper)

Date (MM/DD/YYYY)

Printed name

If signing for the patient, relationship