parkview dentistry

13014 N Saguaro Blvd 203
Fountain Hills, AZ 85268
Tel: (480) 836-1551
www.fountainhillsdentist.com

Appointment Policy

We schedule a dental appointments very carefully to ensure all of our patients are seen promptly. We do this because we value and respect our patient's time and desire to provide the best treatment possible. In order to remain on schedule, we request that you arrive on time for your appointments. If you cannot attend your appointment, please give us 48 hours notification if possible, as we reserve the right to impose a $45.00 NO SHOW fee. I have read and understand the above.

Signed

Notice of Privacy Practices

I,_____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES. Parkview Dentistry of Arizona PLLC.

Print Name

Signature

Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❒ Individual refused to sign
- ❒ Communication barriers prohibited obtaining the acknowledgement
- ❒ An emergency situation prevented us from obtaining acknowledgement
- ❒ Other

Terms of Service

As a condition of your treatment by Parkview Dentistry of Arizona PLLC and/or its employees ("Parkview"), payment or financial arrangements must be made in advance of treatment. For Patients who carry dental insurance, Parkview will prepare the Patient's insurance forms and assist in making collections from insurance companies, and will credit such collections to the patient's account. However, Patient agrees that he or she is personally responsible for payment of all dental products and/or services.

IMPORTANT: All products and services provided by Parkview are also governed by the legal contract available at www.fountainhillsdentist.com/terms (the "Terms"). Patient agrees that, by receiving products and/or services from Parkview, Patient has reviewed and agreed to the terms herein, Patient's treatment plan and Parkview's Terms which together form a binding contract between Parkview and Patient. The Terms are incorporated herein by reference and Parkview's provision of goods and/or services is expressly limited to, and expressly made conditional on, Patient's acceptance of these terms, the treatment plan and these Terms.

Acknowledged and Accepted by Patient:

Name

Date

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X-Ray Request

Patient Name

Address

Phone

Date of Birth _____/_____/_____ *(mm/dd/yyyy)*

I,_____, authorize the release of any and all dental and medical records to Parkview Dentistry Dr. Stacey Laskis. Please send diagnostic radiographs and periodontal charting. Thank you.

Dentist Name

Address

Phone

Fax

Patient / Guardian Signature

Date

Mail copies only to: Parkview Dentistry
13014 N Saguaro Blvd 203
Fountain Hills, AZ 85268.

Or email: info@fountainhillsdentist.com