Practice Consent

Thank you for choosing the practice of **Buckenheimer and Bulnes, DMD, PA.** We are dedicated to provide excellent comprehensive dental care that is personalized in a gentle, caring environment with compassion, integrity and respect.

I, ___________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, oral pathology, pediatric dentistry, limited orthodontics, radiography and cosmetic procedures.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

____
Patient or Guardian Name

_____________________________ _________
Signature Date

_____________________________ _________
Witness Date

Insurance Authorization

I certify that I, and or my dependent(s), have insurance coverage with ____________________ and assign directly to Dr. ______________________ all insurance benefits, if any , otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services.
I am responsible for the full cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

Email Authorization

Your health care is important to us. In order to provide you with the best possible care, we occasionally send convenient electronic messages to our patients about their health care and the products and services we offer.
By providing your email address and or cell number, you are consenting to receive electronic messages for reasons stated in the above paragraph.

Email Address______________________ Cell Phone_______________________

____
Patient or Guardian Name

_________________________________ __________
Signature Date

_________________________________ __________
Witness Date

Written Financial Policy

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- We offer a 5% courtesy accounting adjustment for treatment exceeding $2000 to patients who pay for their treatment with cash or check prior to treatment.
- NO INTEREST Payment Plans from **CareCredit**

Please note:

Buckenheimer and Bulnes, DMD, PA requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We require 24 hours notice to cancel a scheduled appointment. If 24 hours notice is not given the following action will be taken:

- **1st broken appointment-warning and reminder of the cancellation policy.**
- **2nd broken appointment-charge of 50% of the scheduled treatment.**
- **3rd broken appointment-dismissal from the practice-records will be forwarded to your provider of choice.**

Buckenheimer and Bulnes, DMD, PA charges $35.00 for returned checks.

____
Patient or Guardian Name

________________________________ ____________
Signature Date

________________________________ ____________
Witness Date

3906 West Neptune Street Tampa, FL 33629 . 813.259.9000

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Buckenhiemer and Bulnes DMD PA, this ___ day of __________, 20___. A copy of this signed, dated Acknowledgement shall be as effective as the original.

____
Please Print Your Name

____
Please Sign Your Name

If you are the legal representative of the patient, please print the patients' name and describe your authority ____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Christopher M. Bulnes DMD.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's signature on this acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

____
Signature of Privacy Officer