

## Office Policies and Procedures

If this is your first time at the Dental Walk-In Clinic, or you have visited us multiple times but have never had a **Detailed Extensive Comprehensive Oral Examination (ADA Code 160)** understand that you are scheduled for a **Limited Problem Focused Examination (ADA Code 140)**.

I understand that if I am appointed for a **Limited Problem Focused Examination**, and have never had a **Detailed Extensive Comprehensive Examination** performed by a dental professional at the Dental Walk-In Clinic, that the doctor will provide me with a diagnosis of my **chief complaint** (*specific concerns limited to specific areas of the mouth that are specifically requested by you*) but is not responsible for diagnosing other ongoing dental problems, disease, or pathology. I understand that no other areas of the mouth, and no other teeth will be examined, and that it is in my best interest if I do not have a dentist of record to seek a dentist for a **Detailed Extensive Comprehensive Examination**. I understand that the Dental Walk-In Clinic can appoint me at another time to have a dental professional perform a **Detailed Extensive Comprehensive Examination**. I understand that there is a fee for this and all professional services performed at the Dental Walk-In Clinic.

### Patient OR Legal Guardian's Initials

The fee for the **Limited Problem Focused Examination** is **\$75.00**. In most cases a radiograph will need to be taken to help diagnose your **chief complaint**. A single periapical radiograph is **\$35.00 (ADA code 220)** and a panoramic radiograph is **\$90.00 (ADA code 330)**. Extractions are priced upon the difficulty of the procedure. The fees associated with the dental extractions are quoted on a case by case basis. The fee of a simple extraction STARTS at \$85.00 and increases accordingly. The clinical and radiographic examination of the tooth to be extracted along with special considerations such as your medical history, oral hygiene, and your anticipated tolerance to the planned procedures due to extreme pain and or anxiety will help determine the cost of the procedure. Special considerations listed above may affect the cost of other procedures performed by the Dental Walk-In Clinic. The Dental Walk-In Clinic team will present to you all fees associated with performing procedures before procedures are to be performed. I will have the right to question fees and ask for clarification.

**PAYMENT OF FEES IS DUE BEFORE THE PROCEDURE IS TO BE PERFORMED.**

### Patient OR Legal Guardian's Initials

I understand that the dental professional examining me is a general dentist and not a specialist dentist. The dental professional may be unable to treat your condition and if necessary, reserves the right to refer your condition to another dental professional (specialist dentist) or medical professional. The Dental Walk-In Clinic is not responsible if you do not make arrangements to appoint with the professional you were referred to and is not responsible for any fees that you may incur by the professional.

### Patient OR Legal Guardian's Initials

As a courtesy, we will fill out insurance forms for you so that payment will go directly to you, but we cannot be responsible for insurance delays or problems. **We do not accept payments from insurance companies...** all such payments are returned to the insurance companies. The Dental Walk-In Clinic reserves the right not to treat your dental needs. We reserve the right to charge a **\$65.00** appointment cancellation fee if you do not give us 24 hours notice of your wish to cancel the appointment. We reserve the right to cancel your appointment if you are more than 15 minutes late to a scheduled appointment (excluding limited problem focused examinations). We reserve the right to ask you to leave or release you from our care if you; continually miss or are late to appointments, if you are dishonest about your medical history, disrespectful to the Dental Walk-In Clinic team or customers, or are noncompliant (but not limited to) treatment recommendations or instructions.

### Patient OR Legal Guardian's Initials

**HIPAA Acknowledgement** (For a full copy of the Health Information Portability Accountability Act, please ask!)

**Patient or Legal Guardian's Signature of Acknowledgment**

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**Date**

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