Our Office Policies

Welcome to the office of Dr. David Mazza. We would like to share with you our office policies and obtain your acknowledgement as follows:

Updating Medical, Personal and Insurance Data:
I agree to update my (patient's) medical, personal and insurance information at every visit and whenever there is a change.
To the extent permitted under applicable law, I authorize release of any information for dental claims filed by the office of Dr. David Mazza; 4300 Montgomery Avenue Suite 101, Bethesda, MD 20814. My signature below will act as "Signature on File" for Dental Claim forms. I authorize payments from insurance company directly to Dr. Mazza. In case of full payment for services, the insurance check will be refunded to patient. (As a courtesy to our patients we could file claims to insurance companies on behalf of our patients. Our billing and insurance filing system is computerized. This page will be used as your **"Signature on File"** for the appropriate lines on the dental claim forms. If the patient is a minor child, we will need the signature of the parents or guardian.)

Consent to Treatment:
I do authorize Dr. David Mazza and his associate(s), hygienist(s), assistant(s), to perform necessary diagnostic dental procedures and dental treatments, such as X-Rays, Clinical/Para-Clinical Exams; and Clinical / Para-Clinical treatments to discretion of Dr. Mazza and his co-workers. I realize that Dentistry is not an exact science. Therefore I acknowledge that no guarantees have been given to me at the out come of dental treatnment.

Financial Agreement:
I will make sure that I am informed about the details of the treatment plan, alternative treatments their risks and benefits, option of no treatment and its risks and all associated fees. I agree to be responsible for all charges for dental services and materials rendered, unless other arrangements are made with the Office. In case of default of payments and need for collection services, I am responsible for the entire balance due,monthly late fee of $25.00, monthly interest rate of 10% on balance due, collection/attorneys fees (35% of entire balance) and court costs. In case of untimely payment, all promotional rates and professional courtesy discounts would be reversed and I would be charged $40.00 for all returned check(s), stop payment(s) on check(s). Insurance benefits determanation is sole responsibility of patient.As a courtsey the office might assist in insurance benefit determination.

Changes of Appointments:
I agree to $85.00 charge in case of any changes to the made appointments without 48 hour advance notice such as failed appointnments,cancelled appointnment,and being late more than fifteen minutes. (We appreciate at least 48 hours notice for any changes to your already made appointments.)

Intraoral, extra-oral Photography:
I do consent to photos from inside and outside of my mouth and my face. I do agree that these photos could be used for treatment evaluation-purposes, educational presentations and commercial advertisements.

Patient (Guardian) Name _____
Signature _____ **Date**_____