GPS Dental PLLC
Gary P. Skrobanek, DDS
3151 S.E. Military Drive, Suite 115
San Antonio, Texas 78223-3986

In case of **emergency**, whom do we notify? Name: _____Phone: _____
May we thank the person that referred you to us? Name: _____
Address: _____

Acknowledgment of receipt of **Notice of Privacy Practices:** **I,** _____
Printed Name of Patient

Have received a copy of GPS Dental's **Notice of Privacy Practices.**

_____ _____
Signature of Patient/Legal Guardian Date

* * * * * * *

(This section to be filled out by staff at GPS Dental.) Our office made a good faith effort to obtain acknowledgment of receipt of our **Notice of Privacy Practices,** but it could not be obtained for the following reason:

____ Emergency situation kept us from obtaining the patient's signature. _____ Patient refused to sign
____ Language barriers kept us from obtaining the patient's signature. _____ Other, note below:

OFFICE POLICY STATEMENT

All patients shall be treated with the same level of respect and courtesy. In return, we also ask for the same respect and courtesy from all patients with regard to scheduling or changing an appointment.

Please read the following statements and sign below

— Your appointment is a time reserved especially for you. We will be happy to change your appointment with an advanced notification of 24 hours or more during regular business hours (M –F: 8 am- 5 pm). Cancellation on day of appointment or message left on the answering machine will **not** be considered adequate advance.

— If you must change your appointment without advanced notification or if you fail to show for your appointment, please be aware that this office charges a fee ($25 - $100) based on the amount of time that was scheduled for you.

— Payment of above fees may be required before you will be allowed to schedule future visits. Multiple missed appointments or multiple cancellations without advanced notification may require the payment of **anticipated** treatment costs **prior** to treatment **without** being refundable.

— This office uses a collection agency to collect on past due accounts. If your account becomes past due, all collection costs incurred by this office in collecting from you will be your responsibility.

— Payment in full (or estimated patient portion)is expected at the time of service. The following are choices of payment for you:
1. Cash 2. Check (with Driver's License) 3. MasterCard/ Visa/Discover 4. Care Credit

For patients on a limited budget, we can schedule your treatment into smaller segments or you may pre-pay for future treatment in small payments. Please let us know prior to start of treatment.

_____ _____
Patient/Responsible Party Signature Date

GPS Dental
Office Policy for Patients Under the Age of 18

_____ A patient under the age of 18 years of age must have a parent/legal guardian present during treatment.

_____ If the parent/legal guardian is unable to attend the appointment, the parent/legal guardian must select an adult (over the age of 18) to accompany the minor and must furnish us with a signed letter, giving us permission to treat the child without the parent/legal guardian present. (The Letter of Authorization follows.)

_____ If the same selected adult will be bringing the minor child for more than one appointment, the parent/legal guardian may extend the effective date of the Letter of Authorization to include a longer time period.

_____ Without the accompanying parent/legal guardian present or the selected adult and the Letter of Authorization present, we cannot treat the minor patient. The appointment shall be considered as a missed appointment.

Please initial the following statement:

_____ ***I have read and understand the above statements.***

* * * * * * * * * * *

Letter of Authorization for Treatment of Minor Child when Not Accompanied by Parent/Legal Guardian

_____
Printed Name of Parent/Legal Guardian

I, _____ give the following person/s (of legal age) permission to accompany my child to his/her dental visit/s. He/She has my permission to act in my stead and give consent to treatment, x-rays, dental anesthesia, and any other treatment deemed necessary by the dentist.

I may be reached by telephone at: _____

Name of person authorized: _____ Relationship to child: _____

_____ Relationship to child: _____

I realize that I have the right to revoke this Letter of Authorization at any time in writing. The effective date for this Letter of Authorization is as follows:

_____ For my child's appointment on: _____ at _____
Date Time

_____ For all appointments for my child from _____ to _____

_____ _____
Signature of Parent/Legal Guardian Date

* * * * * * * * * * * * * *

Initials of staff member reviewing this letter of authorization: _____