

Philip M. Paleracio, D.D.S. Ltd.
601 South Rancho, Suite B-15
Las Vegas, Nevada 89106
Tel: (702) 385-1166

WELCOME TO OUR OFFICE

We would like to welcome you as a patient. Your initial visit to our office will consist of obtaining a thorough medical and dental history, a full mouth examination, and any necessary X-rays. A description of the treatment needed for your best dental care will be discussed as well as a prognosis, estimated fee, and time required for treatment. You will be encouraged to ask any questions you have regarding your treatment. Our staff is here to work with you as a team to ensure you receive the best possible dental care.

FEES AND PAYMENTS

We offer four payment options:

1. cash
2. check (with a check guarantee card or valid driver's license)
3. credit card: Visa, MasterCard, Discover, or American Express
4. Care Credit (ask our staff to apply for Care Credit)

MISSED APPOINTMENTS

48 hours notice is required to cancel or reschedule an appointment.

By scheduling and not keeping an appointment, you are preventing other patients from being seen by the dentist. Although the dental office makes every effort to confirm appointments the day before, it is your responsibility to keep track of your own appointments. If you fail to provide the dental office with 24 hours notice, a \$25.00 charge will be posted to your account. By signing this document, you agree to pay this charge and understand that no further services will be provided until your balance is paid in full.

INSURANCE

Please remember that most insurance companies DO NOT cover all dental costs. Most companies pay fixed portions of the full charge. It is your responsibility to pay any deductible, co-insurance, or other balance not paid by your insurance company. If your insurance company has not paid your account in full within 45 days of billing, the balance is your responsibility. Please be aware that your insurance company may not cover all services offered by this office.

All co-pays and deductibles are due at the time of service.

WHAT WE NEED FROM YOU

1. Insurance card or information (if applicable)
2. Photo ID

CHILDREN IN THE WAITING AREA

Due to safety considerations, children may not be left unattended in the waiting area, nor may they accompany their parents in the treatment area. Please make appropriate childcare arrangements before arriving at our office so that it will not be necessary to reschedule your appointment.

APPROVAL FOR TREATMENT OF A MINOR

I authorize treatment for _____ by Dr. Philip Paleracio
Dr. Khalaf

Signature of Parent _____ Date: _____

**FOR OUR PATIENTS UNDER THE AGE OF 18, A PARENT OR
GUARDIAN MUST REMAIN IN THE FACILITY FOR THE DURATION
OF TREATMENT.**

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any benefits or medical information necessary to process claims, and I authorize payment of dental benefits otherwise payable to me to Philip M. Paleracio DDS Ltd. for services rendered.

Subscriber Signature: _____ Date: _____

PAYMENT POLICY

I understand that I am financially responsible for charges not paid by my insurance. I understand that reasonable collection charges may be applied in order to collect any unpaid charges. Such collection charges will include an interest charge on all balances not paid in full within six months.

Responsible Party
Signature: _____ Date: _____