Dental Patient Contract

Patient Name: _____

Date of Birth: _____

Partnership Health Center
Missoula's Community Health Center

This contract is a mutual agreement between Partnership Health Center Dental Clinic and I.
This contract does not require me to have my dental treatment completed at Partnership Health Center.

My Agreement

- I will brush and floss daily as recommended by my dental team.
- I will have my teeth cleaned every 3-12 months, as prescribed.
- I will have a yearly dental exam and follow through with my treatment plan.
- **I will arrive on time, but preferably 15 minutes early for my appointments. If I am 10 minutes late, my appointment may be re-assigned to an emergency patient and I will receive a 'no show' on my account. I will call 24 hours in advance if I can't come to my appointment. If I do not give 24-hour notice I understand that I will be considered a 'no show' for my appointment(s).**
    - After my first no show, I will not be able to schedule again for 3 months.
    - After my second no show, I will not be able to schedule again for 6 months.
    - After my third no show, I will not be able to schedule again for 1 year.
    - After my fourth no show, I will only be seen on an emergency basis or same day basis. I have been informed that these appointments are only available on a walk-in, first-come-first serve basis.
- **I will bring my $27.00 nominal fee to each dental appointment. If I do not have it, my appointment will be re-scheduled; my minimum payment is $5.00 if I have Full Medicaid Coverage.**
- **I understand that it is my responsibility to bring in my income verification as requested to qualify for and stay current on the sliding fee scale.**
- **I understand that my dental treatment will be billed per procedure, based on my sliding fee scale assignment.**
- **I understand that I will not be able to schedule appointments if my bill exceeds a balance of $300.**
- I will pay a down payment if required for treatment on or before the day my appointment is scheduled as directed by reception.
- I am aware that if it has been more than 18 months between dental cleanings and/or exams, I will lose my standing as an established PHC dental patient. I understand that it is my responsibility to call to schedule a New Patient exam to re-establish my dental care, and that I will not be given priority over any other person(s) requesting these appointments.

Partnership Health Center's Agreement

If you are cooperative and abide by your part of the above contract, the Dental Clinic will:

- Complete your dental treatment needs within one year of this agreement, including extractions, fillings, cleanings, and necessary referrals.
- Schedule my follow up treatment appointments when you check out from your visits, if appointments are available.
- Discuss your oral health needs with you, including: brushing, flossing, and the importance of cleanings.
- Help you set up a payment plan to cover the cost of your dental care.

I have read the above Dental Patient Contract. I would like my dental treatment completed at Partnership Health Center. I understand that failing to keep my part of the agreement may lengthen my treatment beyond one year.

_____

Patient Signature ***Date***