Office of **Keerthi Senthil DDS, MS**
72027 Desert Drive, Rancho Mirage, CA 92270
(760) 340- 5107

Patient Rights- Access to Your Medical Records

You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format requested by you unless we cannot practicably do so. Please make this request in writing, to obtain your health information. We will charge a reasonable cost-based fee for expenses such as copies, information for a fee as well. Contact us for further information.

Privacy Practices Acknowledgment

I, _____ have received a copy of the Privacy Practices from Keerthi Senthil, DDS, MS

Patient Name _____ Phone _____

Email _____

Address _____

City _____ State _____ Zip _____

Patient Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

Consent for Services

You have the right as a patient, to be informed about your condition and the recommended dental, medical or diagnostic procedures to be used that you make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is meant not to alarm you rather it is simply an effort to make you better informed so you may give or withhold your consent to a procedure.

I, _____ consent to be a patient of Keerthi Senthil, DDS, MS and agree to radiographic and clinical examination. I also understand the following:

1. During the course of treatment, I may undergo procedures in all places of dentistry and medicine, including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, radiography, and saliva DNA testing.

Initials _____

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

Initials _____

3. No guarantee nor warranty can be made about treatment outcomes, restoration longevity, nor prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

Initials _____

4. I will pay in advance any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for all costs of my insurance does not cover.

Initials _____

5. My treatment plan may change over time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist and dental office staff.

Initials _____

Financial Policy

Payment is due when services are rendered. For payment options, you may apply for a payment plan through Care Credit Dental Fee Plan, which must be arranged and approved in advance of your treatment appointment. As a courtesy to our patients who have dental insurance and medical insurance coverage, we will file your claim electronically. Your deductable and co-payment are due the day of service. Any amount exceeding your plan's annual maximum amount is due when service is rendered. Please give our office at least 24 hour's notice to cancel or re-schedule an appointment.

A minimum fee of $50.00 will be charged for missed appointments. We appreciate your cooperation, Thank You.

Signature _____ Date _____