WE ARE GLAD YOU CHOSE AMC FOR YOUR HEALTH CARE PROVIDER!

To better serve and ensure we can reach you, Alliance Medical Center (AMC) will ask for a patient's email and cell phone number. Per AMC's Notice of Privacy Information, we do not share patient contact information without a patient’s mutual consent.

Please review the following health center policies:

- For your 1st appointment the following are required:
  - Photo identification and insurance cards (as applicable)
  - Completed Patient Information form (Please include current cell phone and email on every form)
  - Completed Patient Health Questionnaire form
  - Completed Consent for Treatment form
  - Bring all medications that you are taking including vitamins
  - If you are uninsured, a deposit of $100.00 may be requested at your 1st appointment. The actual cost may be more or less. (Please see Sliding Scale Policy form regarding our discount program)
  - If you have a managed health plan (Partnership, HMO) Alliance must be designated as your PCP

*Failure to bring all of these to your first appointment, may result in forfeiture of the appointment*

Late Arrival: If you are more than ten (10) minutes late for your scheduled appointment time the appointment may need to be rescheduled. We also have telephone and televideo appointments, tell us if that may be easier for you.

Deductibles, Co-pays, and sliding scale fees: Must be paid at the time of service unless other prior arrangements have been made. We accept cash, check, debit and credit card.

All Visits: Please present your photo identification and insurance cards at every visit. Bring medications and/or any logs.

Medication Refills: Need to be requested through your pharmacy. A refill request may take up to three (3) business days to process.

Telephone Hours: Monday through Friday 7:30am—5:30pm (for after hour service see the information page).

Controlled Substances: In an effort to improve access to primary medical care and comply with new prescription regulations Alliance Medical Center will not be prescribing any controlled substances to new patients.

Automated Appointment Confirmation and Reminders: Alliance Medical Center’s uses an automated and text messaging services to confirm your appointment 48 hours in advance. It is your responsibility to confirm your appointment.

Medical Records: Please allow three to five (3-5) business days to copy records and/or complete forms.

THANK YOU FOR CHOOSING ALLIANCE MEDICAL CENTER
WE LOOK FORWARD TO PROVIDING CARE FOR YOU
Alliance Medical Center’s sliding fee allows our patients to pay according to their income and services rendered. We will provide AMC services at low cost based on your gross monthly income and number of people in your family. To be able to participate in this program you must show evidence of your income, the verification of income can be one of the following:

- most recent income tax return,
- most current 1 month of check stubs,
- Or a current letter from your employer regarding your wages.

Renewal of the program will be every 6 months or 12 months depending on verifications.

You will have 30 days to provide Alliance Medical Center with evidence of income or you will be charged full price for the services rendered.

### Payment at Time of Service

Payment at time of service is expected at each visit; however, no patient is turned away for inability to pay. Once you qualify for our sliding scale program any lab tests that are performed will be covered at Quest Laboratory (located throughout the county).

We have the ability to provide assistance with several applications for programs that include:

- Medi-Cal
- Covered California
- AIM
- Cal Fresh

To see if you qualify for any of the programs, our receptionist can schedule an appointment to speak with our Patient Navigator.

Let us know if there are any questions regarding your payments. Our goal is that you receive the best health care possible.

### After hours coverage

Alliance Medical Center has a medical provider on call 24 hours a day, 7 days a week. If you need to speak to the on call medical provider, please call 707-433-5494 and speak to the operator. The operator will then connect you with the on call medical provider/dentist.

Partnership Health Plan members, medical services only, can also call the Advice Nurse line at 866-778-8873. The Advice Nurse is available to you 24 hours a day, 7 days a week. You can use this free service if you are not sure if you should go to the emergency room or if you have a medical question that cannot wait until the next day.

*If you have a life-threatening emergency, you should go to the closest emergency room or call 911.*

### Clinic Hours

<table>
<thead>
<tr>
<th>Clinic Hours</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Healdsburg</strong></td>
<td>7am – 7pm</td>
<td>7am – 7pm</td>
<td>8am – 7pm</td>
<td>7am – 7pm</td>
<td>8am – 5pm</td>
</tr>
<tr>
<td><strong>Medical Windsor</strong></td>
<td>7am – 6pm</td>
<td>7am – 5pm</td>
<td>7am – 6pm</td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
</tr>
<tr>
<td><strong>Dental Healdsburg</strong></td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
</tr>
<tr>
<td><strong>Dental Windsor</strong></td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
<td>8am – 5pm</td>
<td></td>
<td>8am – 5pm</td>
</tr>
<tr>
<td><strong>Comprehensive Wellness Center</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10am – 7pm</td>
</tr>
</tbody>
</table>
Patient Name/Nombre del Paciente ________________________________________

Date of Birth / Fecha de Nacimiento ______/______/________
Male/Masculino □ Female/Femenino □

Physician Name / Nombre de su Medico __________________________ Phone# / #Teléfono ______/______/______

Last Exam Date / Fecha de su último examen Medical/Medico _____/_____/______ Dental _____/_____/______

□ yes/si □ no Have you had any recent illnesses? Ha tenido usted una enfermedad reciente?
□ yes/si □ no Have you been hospitalized? Ha sido hospitalizado alguna vez? Date / Fecha _____/_____/______
□ yes/si □ no Have you had any operations? Ha tenido alguna operación? __________________

□ yes/si   □ no High or Low Blood Pressure / Presión Alta o Baja
□ yes/si   □ no Diabetes / Diabetes
□ yes/si   □ no Heart Murmur / Soplo Cardiaco
□ yes/si   □ no Artificial Joints, hip, knee, etc. Metal pins, plates / Articulaciones artificiales como cadera, rodilla, etc. Placas de Metal o Tornillos

□ yes/si   □ no Shunts, Stents, Pace Maker / Anastomosis, Derivaciones, Marcapasos
□ yes/si   □ no Hepatitis / Hepatitis
□ yes/si   □ no Cancer and cancer treatment / Cáncer y tratamiento del cáncer
□ yes/si   □ no Have you ever taken Phen-Fen Redux? Ha tomado pastillas para perder peso como Phen-Fen Redux?
□ yes/si   □ no Stroke / Derrame Cerebral (Apoplejía)
□ yes/si   □ no Bleeding Tendencies, Hemophilia / Tendencia a sangrar, Hemofílico
□ yes/si   □ no Anticoagulants, blood thinners (Aspirin, Coumadin) / Anticoagulantes (Aspirina, Coumadin)
□ yes/si   □ no Medications for Osteoporosis / Medicamento para Osteoporosis
□ yes/si   □ no Arthritis / Artritis
□ yes/si   □ no Kidney Disease / Enfermedad del riñón
□ yes/si   □ no Liver Disease / Enfermedad del hígado
□ yes/si   □ no Ulcers / Ulceras
□ yes/si   □ no Thyroid / Tiroides
□ yes/si   □ no Cholesterol / Colesterol
□ yes/si   □ no Seizures / Convulsiones
□ yes/si   □ no Anemia / Anemia
□ yes/si   □ no Depression / Depression
□ yes/si   □ no Asthma / Asma
□ yes/si   □ no Emphysema / Enfisema
□ yes/si   □ no Do you smoke? / Fuma?
□ yes/si   □ no History of drug abuse? / Historia de abuso de drogas?
□ yes/si   □ no AIDS / SIDA / HIV+

Have you become sick from, shown allergy to or been told not to take or use any of the following?
□ yes/si   □ no Penicillin or other antibiotics? / Penicilina u otros antibióticos?
□ yes/si   □ no Aspirin, Codeine or other pain medications? / Aspirina, Codeína u otros medicamentos para el dolor?
□ yes/si   □ no Novocaine, Xylocaine or other local anesthetics? / Novocaína, Xylocaina u otro anestésicos?
□ yes/si   □ no Latex allergy? / Alergia al látex?

Is there anything of importance in your medical history that has not been asked? ________________________________

Please list all daily medications: / Por favor anote todos los medicamentos que toma diariamente:
__________________________________________________________________________________________

WOMEN / MUJERES:
□ yes/si   □ no Are you pregnant? / Esta usted embarazada? Due Date: _____/_____/______
□ yes/si   □ no Are you nursing? / Esta amamantando?
□ yes/si   □ no Are you taking birth control pills? / Está tomando anticonceptivos?

Patient/Parents | Firma de Paciente/Padre ___________________________ Date/Fecha __________________

Doctor ______________________________
### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Social Security Number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Aliases/Preferred Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male/Female/Unknown/Non-binary/X</td>
</tr>
<tr>
<td><strong>Home Address</strong></td>
<td>Street/City/State/Zip</td>
</tr>
<tr>
<td><strong>Home Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cell/Mobile Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Interpreter Needed</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td><strong>Preferred Language</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>Black/African American/White/American Indian/Native Hawaiian/Pacific Islander/Asian/Chinese/Hawaiian/Alaskan Native/Paciific Islander/Unknown</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td>Hispanic/Non-Hispanic/Patient Refused/Unknown/Alaskan Native/Asian/Pacific Islander/Unknown/Unknown/Hispanic/Group Refused/Unknown</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Divorced/Domestic Partner/Same Sex/Single/Married/Legally Separated/Other/Unknown/Widowed/Other</td>
</tr>
<tr>
<td><strong>Homeless</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td><strong>Veteran</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td><strong>Migrant/Seasonal</strong></td>
<td>Migrant/Seasonal/Neither</td>
</tr>
<tr>
<td><strong>Agricultural/Winery Work</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td><strong>Communication Preferences</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employer Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employer Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Work</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family Members seen at Clinic</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family Income</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family Size</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Driver’s License Number</strong></td>
<td></td>
</tr>
</tbody>
</table>

### PERSON RESPONSIBLE FOR PAYMENT

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mailing Address</strong></td>
<td>Street/City/State/Zip</td>
</tr>
<tr>
<td><strong>Home Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cell Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male/Female</td>
</tr>
<tr>
<td><strong>Preferred Language</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employer Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employer Phone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Insurance Type</strong></td>
<td>Medi-Cal/ID#/Private Insurance/Work Injury/Medicare/ID#/No Insurance</td>
</tr>
<tr>
<td><strong>Insurance ID#</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Group #</strong></td>
<td></td>
</tr>
</tbody>
</table>

### INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Insurance Carrier Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Insurance ID#</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Group #</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Subscribers Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Subscriber Date of Birth</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Name on Insurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Secondary Insurance Carrier Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Insurance ID#</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Group #</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mailing Address</strong></td>
<td>Street/City/State/Zip</td>
</tr>
</tbody>
</table>

**For patients 12 years and older**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex assigned at Birth</strong></td>
<td>Male/Female/choose not to disclose/intersex/unknown</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td>Straight (not lesbian or gay)/bisexual/choose not to disclose/lesbian/gay/pansexual/queer</td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
<td>Female/Male/transgender/male-to-female/transgender/female-to-male/other/choose not to disclose/non-binary/queer/questioning</td>
</tr>
<tr>
<td><strong>Patient’s Pronouns</strong></td>
<td>she/her/hers/he/him/his/they/them/thiers/ze/zi/hirs/ey/ez/em/ehirs/x/e/xem/xirs/ve/vir/vis/other/patient’s name/decline to answer/unknown</td>
</tr>
</tbody>
</table>

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**LABEL**
ELECTRONIC HEALTH INFORMATION EXCHANGE NOTICE
AMC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share electronically (when appropriate) clinical information with other physicians and health care providers that participate in the HIE network. Using HIE helps all of your health care providers more effectively share information and provide you with better care. The HIE network through the Redwood Community Health Coalition also enables emergency medical personnel and other providers who are treating you to immediately access medical data about you that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. Information regarding drug and alcohol treatment is unavailable except in emergencies. However, you may choose to opt-out of participation in the AMC HIE, or cancel an opt-out choice at any time.

I understand that my records are shared in the HIE unless I opt-out.

NOTICE OF PRIVACY PRACTICE
AMC adheres to all state and federal regulations as they apply to the access, protection, disclosure and use of your healthcare information contained in our records. The AMC Notice of Privacy Practices (available at the Reception desk and on our website: https://alliancemed.org/patient-support/) tells you how AMC will use, disclose and manage this protected health information about you. The Notice of Privacy Practices also provides you with details regarding the how AMC protects the privacy and security of your record.

I have been advised and understand that AMC’s Notice of Privacy Practices is available to me by asking for a printed copy at any of our clinic locations. I also understand that it is posted and available on-line on AMC’s website.

ALCOHOL AND SUBSTANCE ABUSE TREATMENT RECORDS
I understand that any records pertaining to alcohol and/or substance abuse treatment are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2 (Substance Use Disorder regulation) and cannot be disclosed without my written consent unless otherwise stated in the regulation. I also understand I can revoke this consent at any time except to the extent that action has been taken in reliance on it.

The following information is also available to you upon request at any of the clinic locations.
Appointment Policies
Notice of Privacy Practices
Advance Directives
Patient Complaint Policy
Patient Right & Responsibilities

Our staff is available to assist you in this process if needed. Please note, by signing, you are confirming that you have read or have access to the documents above. For additional questions, contact:

Operations Manager or Member Service Supervisor
Alliance Medical Center
1381 University Ave.
Healdsburg, CA 95448
(707) 433-5494

Signature of Patient or Legal Guardian
Date

Print Name of Legal Guardian (if applicable)
Relationship to Patient
PATIENT RELESE OF INFORMATION AND FINANCIAL RESPONSIBILITY FORM

Last Name ___________________  First _____________________  Date of Birth ________________

TREATMENT/RELEASE OF INFORMATION
I request Alliance Medical Center (AMC) to provide me and/or my family with medical care and understand that.

Alliance Medical Center takes the privacy of my health information very seriously. As a courtesy to you, AMC will bill your insurance company and must share certain information with the insurer in order to process claims.

MEDI-CAL PATIENTS
The Qualified Service Organizations (QSO) listed below contract with the State of California to provide health care services to Medi-Cal members. Medi-Cal may assign you to one of the QSOs to manage your services. The QSOs process claims for services submitted by AMC. The QSOs are also required to submit information on all claims paid or processed to California Medi-Cal for administration purposes.

I authorize AMC to disclose my health information, including information related to my treatment for alcohol and/or substance abuse, to Beacon Health, Medical Consultants, Hospitals Partnership Health Plan for the purpose of submitting claims for payment to the QSO and to other organizations for continuity of care.

ALL OTHER INSURANCE PLANS
I hereby authorize AMC to disclose my health information, to consulting medical providers, hospitals, and other specialists for the purpose of claims processing. This may include releasing certain information related to my treatment for alcohol and/or substance abuse to my insurance payer for the purpose of submitting claims for payment for services provided.

GUARANTEE OF PAYMENT
I acknowledge my responsibility to pay for that care according to the fees established by AMC if and to the extent my insurance does not cover the services provided.

ASSIGNMENT OF BENEFITS
I authorize my insurance carrier to pay directly to AMC benefits that I am entitled to for services provided to me/my family by AMC. I hereby assign these benefits for medical service to AMC.

TREATMENT / PAYMENT AGREEMENT
I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand I can request of list of disclosures if I do provide written consent.

I understand and acknowledge the following:
- My treatment may not be conditioned upon or withheld if I do not sign this form
- I have received a copy of this signed document
- I understand that I may revoke this authorization at any time by giving written notice to AMC, except to the extent that AMC or QSO has already acted in reliance upon it.

________________________________________  __________________________
Signature of Patient or Legal Guardian  Date

________________________________________  __________________________
Print Name of Legal Guardian (if applicable)  Relationship to Patient

Reversal: I revoke my authorization for disclosure of information related to substance use disorder (SUD) to my payer(s).

________________________________________  __________________________
Signature of Patient or Legal Guardian  Date
Our goal is to provide quality health care in a timely manner. “No-shows” and late cancellations make it hard for other people to get an appointment. Here is our policy about missed appointments. It helps us make sure there is access for all of our patients in need of medical care and specialty services.

- Our automated service will call or text you to confirm your appointment 48 hours in advance. However, if we are unable to reach you, we will leave you a message regarding your appointment. **It is your responsibility to confirm your appointment.** You can confirm your appointment by calling us at 707.433.5494
  
  Patient Initial__________

- If you must cancel an appointment, please call 707.433.5494 24 hours in advance of your scheduled appointment. If you do not reach the receptionist, you can leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave a phone number for us to contact you. We will return your call and offer you the next available appointment.
  
  Patient Initial__________

- On Time Arrivals: If you are more than 10 minutes late to your appointment, we may give your appointment to another patient. This will be considered a missed appointment. Please be on time!! We also offer televideo and telephone visits if that is easier for you. Ask.
  
  Patient Initial__________

Alliance Medical Center requires patients to consistently keep appointments or call within 24 hours of the scheduled appointment if they are unable to keep the appointment. If it is easier for you, we offer Walk-In Status. Walk-In Status is for a patient that has a difficult time making a scheduled appointment, or who has lost scheduling privileges due to four (4) missed medical appointments during a 12 month period (for any AMC specialty services and other services designated specialty services two (2) missed appointments may result in walk-in status). A patient who has lost scheduling privileges will be placed on a walk-in status for one year. Walk-in patients are advised to check in at the front desk at 8:00am to request an appointment, and will be directed to wait for the next available Provider. Alliance Medical Center will attempt to address the patient’s medical needs. If no appointments are available, the patient will be given the option to wait or return.*

  Patient Initial__________

- Virtual Visits: Alliance Medical Center is offering virtual visits. A virtual visit is an appointment with your doctor conducted remotely by video using a smartphone, computer or tablet.
  
  Patient Initial__________

- I prefer the appointments be confirmed at this number:
  
  Phone Number____________________

Your help in keeping your medical appointments enables us to better utilize available appointments for our patients in need of medical care. 

* Procedure for Walk-in appointments may be subject to change based on external factors.
CONSENT FOR TREATMENT

Health Professionals must provide prospective patients with information regarding their proposed treatment. For this reason, consent must be obtained for any dental procedures which might be of concern to the patient or parent. Considering all risks, benefits and alternatives of dental treatment, informed consent indicates you have been provided sufficient information to allow you to make an informed personal choice concerning the dental therapy for you and your dependents. After you are sure that you understand the information about the treatment recommended, and if you agree to receive this type of treatment, you must sign this form to indicate that you understand and consent to the treatment.

1. I hereby authorize and direct the dentist, dental hygienist, or other dental auxiliaries to perform upon me or my dependents the following dental treatment or oral surgery procedure, including the use of an necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

2. In general terms, the dental procedure(s) or operation will include:
   - Cleaning of teeth and application of topical fluoride.
   - Application of sealants to the grooves of teeth.
   - Treatment of diseased or injured teeth with dental restoration.
   - Removal (extraction) of one or more teeth.
   - Treatment of diseased or injured oral tissues (hard and soft)
   - Use of sedative drugs to control apprehension and/or disruptive behavior and/or use of Nitrous Oxide (N2O)
   - Endodontic Services (Root Canal)
   - Fixed prosthetics (Crown and Bridges)
   - Replacement of missing teeth with dental prosthesis (Full and Partial dentures).
   - Other

3. I understand that at this time, the Alliance Dental Center provides comprehensive general dentistry services. Referrals may be made for:
   - Orthodontic
   - Endodontist
   - Oral Surgery
   - Pediatric Dentistry
   - Prosthodontist
   - Periodontal
   - Other specialists not mentioned.

4. I understand that in the course of treatment, the dentist may discover other or different conditions, which require additional or specialists to perform such other procedures as are advisable in their professional judgment as limited by the prescribed plan of treatment.

5. Additionally, I understand that the administration of medication and performance of restorative and/or surgical dental procedures carry certain common inherent risks but not limited to:
   - Drug reactions and side effects.
   - Post-operative bleeding.
   - Post-operative infection, swelling, or bone inflammation.
   - Possible involvement of the sinus of the upper jaw during removal of upper teeth, requiring possible surgery for repair at a future date.
   - Possible involvement of the nerve within the jaw during the removal of teeth and other procedures, which might result in usually temporary, but possible permanent numbness and/or tingling in the lip and tongue.
   - Possible fracture of the jaw, teeth or fillings during the procedure.
• Bruising and/or vein inflammations at the site of the injection(s).
• Aspiration or swallowing of foreign objects including, but not limited to teeth, dental materials and dental instruments.

6. Even though their occurrence is extremely remote, some risks are known to be associated with dental treatment, oral surgery procedures, and the use of drugs (including but not limited to local anesthesia, drugs and premedication/sedative agents). I understand that certain complications may result from the use of any anesthetic and/or sedative agent, including respiratory problems, allergic reactions, convulsions, cardiac arrest, brain damage, and loss of function of any organ. I accept that complications may require hospitalization and may even result in death.

7. The proposed treatment and the benefits will be discussed with me, before the initiation of the proposed procedure. Alternate methods of treatment if any, will also be explained to me, including the advantages and disadvantages of each. I have the right/duty to ask questions about my or my dependents condition, alternative forms of treatment, the risks of non-treatment, the procedure to be used, and the risks and hazards involved. I am advised that even though good results are expected, the possibility and nature of complications cannot be accurately anticipated in all cases, and therefore, there can be no guarantee as expressed or implied, either as to the results of the treatment, or as to the cure. I understand that should I decide not to proceed with recommended treatment or referral I will be asked and agree to sign a declination form.

8. I have answered all the questions about my or my dependents medical history and present health conditions fully and truthfully. I have told the dentist or other clinic personnel about my conditions, including allergies, which might indicate that my dependent or I should not receive injectable/oral medication and/or sedative agents. I also understand that if my dependent or I ever has any changes in health status or any changes in medication(s). I will inform the doctor at the appointment. I understand I may be asked to provide information regarding my medical records and give consent for records request as needed.

For foster parents, adopted parents and legal guardian’s proof of legal guardianship for patient under 18 yrs of age will be required.

I have read the form or the form has been read to me, and I understand the meaning of its contents. All questions have been answered to my satisfaction, and I believe that I have sufficient information to give this informed consent.

Signature: ___________________________ Date: ___________________________

Relationship if signature is other than the patient: ___________________________

Initial by indicating following information was received:

_______Dental Material Fact Sheet
_______Nitrous Oxide Information
_______Minor Policy (if applicable)
Alliance Dental Clinic participates in Medi-Cal, MetLife PPO, Guardian, Premier Access PPO and Delta Dental PPO/Premier Provider. Alliance Medical Center will be happy to bill your dental insurance for you. You are responsible to pay for co-payments, deductibles and other non-covered portions at the time of the visit.

**Amal vs Comp - All insurances**
If composite fillings on molars are not a benefit, patient/responsible party is responsible for the difference between the amalgam/composite (molars). Payment due at the time of service otherwise amalgam fillings will be placed.

**Patients with insurance** by signing this financial agreement I’m aware I share responsibility to track my year annual maximum. I am also aware I am responsible for any optional treatment and non-covered services rendered.

**Filling replacements** done with in time frame not allowed by insurance company (if applicable) due to material failure, will be replaced at no charge. Customary and usual mechanical wear will be patient’s responsibility. Fractures do to traumatic injury will also be patient responsibility.

**For patients without insurance coverage** Alliance Medical Center offers patients a sliding fee scale discount. To qualify for a discount you must present proof of income and must pay for the service at the time of the visit.

All other patients are asked to pay for their services at the time of the visit. For patients unable to pay their balance at the time of service a written payment plan can be arranged.

**Treatment Plan:**
Signature on the treatment plan indicates that I have reviewed all treatment options listed with my provider.
I agree that I, or the person delegated by me as responsible party on this account, is responsible for all fees related to treatment rendered at the AMC Dental Clinic.
Treatment plan is an estimate not a bill. Estimated prices will be honored for 1 year from date of exam. Prices and treatment are subject to change if indicated by provider.

Please feel free to notify us with any questions about our payment policy.

I have read and understood the above policy.

______________________________  _________________________
Signature  Date

______________________________  _________________________
Print Name of Legal Guardian (if applicable)  Relationship to Patient