PATIENT RIGHTS AND RESPONSIBILITIES

We are dedicated to providing quality dental care in a respectful environment. This form outlines your rights and responsibilities as our p atient. Please read, ask questions, and sign below.

Your Rights

You are entitled to:

Respectful Care: Compassionate, confidential treatment protecting your privacy (per HIPAA).

Clear Information: A thorough dental exam, medical history review, and understandable explanation of your treatment plan, risks, benefits, and costs.

Choice: Input into your treatment, the right to refuse or pause treatment, and information on risks of no treatment.

Timely Care: Scheduled treatment and access to emergency care (call [Clinic Phone Number]).

Fair Treatment: Care without discrimination based on race, ethnicity, religion, gender, sexual orientation, or disability.

Support: Accommodations (e.g., wheelchair access, large print), clear fee explanations, and access to our grievance process (contact [Clinic Contact Name/ Number]).

Your Responsibilities

You agree to:

Attend Appointments: Keep scheduled visits or reschedule/cancel 48 hours in advance (call [Clinic Phone Number]). Missed appointments may incur fees or pause treatment.

Pay for Services: Pay as agreed after your treatment plan discussion. Unpaid balances may pause treatment.

Maintain Oral Health: Brush, floss, and attend recall visits. Non-compliance may lead to treatment discontinuation.

Communicate: Update us on health changes and ask questions to support your care.

Acknowledgment

I understand my rights and responsibilities and agree to partner with Alex Hoyos DDS.MS.PA for my dental care.

Patient Name: _____

Signature: _____ **Date:** _____

Doctor Name: _____

Signature: _____ **Date:** _____