



## Welcome!

We appreciate the confidence and trust that you have placed in us and look forward to getting to know you!

Dr. Koutsil graduated from the College of Dentistry at the University of Saskatchewan in 2006. He then moved to Alberta with his family, where he began practicing dentistry in High River. In early 2010, he took over the clinic at this location.

Dr. Koutsil and the Shawnessy Smiles team are committed to furthering our education by attending continuing education programs & courses, so we can offer you the latest in dental advancements.

## Privacy Act

Initial

Shawnessy Smiles complies with the Alberta Personal Information Act (PIPA) and the Health Professions Act in regards to the management, collection, destruction, use and disclosure of our patient's personal dental/medical history information.

## Appointment Policy

Initial

If you are unable to keep your scheduled appointment we will require **2 business days' notice** per appointment to avoid a missed appointment fee of **\$50**. Unfortunately, should any patient be more than **10 minutes late** we will not be able to provide treatment that day. Please ensure you are aware of all the appointments you make with our office, so that you and other patients receive dental care in a timely matter.

## Insurance

Initial

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility** to know the details involved in your plan such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. Shawnessy Smiles can also provide estimates when requested so you may budget your finances accordingly.

**We offer the following payment options. Please SELECT which option you would like to participate in.**

### Option A:

Payment is due in full on the day treatment is rendered. We accept Cash, Debit, Visa, MasterCard and American Express. We will process your payment on the day treatment is rendered and assist in the submission of the necessary documents to your insurance carrier. The payment from insurance will be sent directly to you, the patient, by either cheque or direct deposit depending on how your plan was set up by you or your plan administrator.

### Option B:

We will directly bill your insurance company on your behalf and collect payment from them. If we receive an explanation of covered costs from your insurance at the time of your visit, you will be required to pay the outstanding balance before you leave. In the event an explanation of covered costs is unknown, or, in the case of dual insurance, any balance owing by the patient will be collected after the insurance responds. See the [Express Checkout Form](#) for faster payment options.

Please sign below acknowledging that you have read and understand the office policies of Shawnessy Smiles.

Signature:  Date:



**Express Checkout (Optional)**

Date: \_\_\_\_\_

In order for us to facilitate your billing and payment process, you can have us bill your Visa, MasterCard, American Express or your Debit Credit Card. You will be billed once payment from the insurance is received.

I, \_\_\_\_\_ understand that payments will be applied to my credit card for myself and the following family members: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Balances under the dollar amount selected below, will be automatically applied to this card once payment from insurance is received, and a receipt will be mailed once completed. You will be notified of balances over the amount selected so you may authorize payments or arrange another form of payment. Missed appointment fees will not be charged on your card automatically, we will call for authorization.

Please select a minimum charge amount

\$50.00     \$75.00     \$100.0     Other \$\_\_\_\_\_

For security purposes, your credit card information will be completely removed from our records upon your request or discharge from the practice.

Credit Card Information:

Visa     MasterCard     American Express     Debit Credit Card

Card Number: \_\_\_\_\_

Expiry: \_\_\_\_/\_\_\_\_    CVV \_\_\_\_\_

Cardholder Name (as it appears on card): \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_