Consent for Services & Financial Policy

Thank you for choosing our office as your dental care provider. We are committed to the success of your treatment. The following is a statement of our Consent for Service & Financial Policy, which we require you to read and sign prior to any treatment.

Please initial after each statement acknowledging that you have read and agree to the contents.

____I hereby authorize the doctor and/or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of me or my child's dental condition(s).

____Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

____I agree to the use of local anesthetics, sedatives, and other medications as necessary. I fully understand an anesthetic agent embodies certain risks.

Financial Policy:

____Payment in full is due at the time of service. We accept Cash, Personal Check, Visa, Master Card, Discover, American Express, Debit Cards, and Care Credit patient financing. Please be aware that a $35.00 fee will be charged for all returned checks.

____If you do not have dental insurance, we will collect the amount due for services at each appointment.

____I understand that it is ultimately my own responsibility to know who my insurance carrier is, and what coverage made available to me.

____If you have **DELTA DENTAL PRIMERE/PPO or CIGNA PPO** (in-network with Cigna PPO until January 31, 2018) insurance, we will do our best to confirm your coverage and you will be asked to pay only the ESTIMATED part of your bill at the time of service; that we think your insurance will not cover. However, do not file secondary insurance, that will be your responsibility to ask for any necessary forms and x-rays to send. Any unpaid balance can be charged on all accounts 60 days or more past due. Further collection activity and credit reporting will be initiated on all 90 days or more past due balances.

____We **CANNOT** guarantee what your insurance company will pay; we simply estimate the amount most insurance companies pay based on most traditional plans. We can submit a pre-treatment estimate before any major work is started (crowns, bridges, implants, dentures, etc.) to your insurance company. All major dental work is required to be paid in full before cementation or delivery.

____Your insurance policy is a contract between you and your insurance company. You are our patient and we will treat you, not your insurance company. If your insurance company has not paid your account in full within 60 days, the balance will be sent to you in the form of a statement. You will then

have 21 days from the date of your statement to remit payment to us. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the dental provisions of your insurance plan. I understand that the co-payment or patient portion of payment is only an **ESTIMATE** and I will be responsible for any balance after the insurance payments are made.

____I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or practice and to be applied directly to any outstanding balance on my account.

____Adult patients are responsible for payment at the time of service. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied, unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash at the time of service.

BROKEN APPOINTMENT POLICY: When you make your appointment, the doctors' and staffs' time is specifically reserved for you. When you cancel your appointment without giving us a 48 hour notice, the time we have reserved for your appointment cannot be replaced. Our office will charge and collect the full amount of your missed appointment fee of $85.

____I understand that any appointment over an hour in length will be charged an $85.00 cancellation fee if the appointment is canceled with less than 48 hours notice.

____I understand there will be a $200 deposit collected for any appointment over 1 1/2 hour. Refundable with 48-business hour notice (Saturday and Sunday are not business days).

____I understand that I will need to request in writing and pay a reasonable administrative fee if I want to have copies of my records.

Printed name of patient, parent or guardian/responsible party):_____

Signature: _____

Doctor/Staff Signature:_____Date: _____