Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL
Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

PAYMENT
Payment for service is due at the time services are provided unless other **payment arrangements** have been approved in advance. We accept cash, checks, Visa, Mastercard, America Express, and Discover. You might also be interested in taking advantage of one of our financing options we have available through third party financing. By utilizing this wonderful finance option, your entire family will enjoy the excellent treatment we provide with minimum easy-to-budget monthly payments. They offer a variety of **INTEREST FREE** financing including plans with 3,6,12 and 18-month option (if you qualify)

DENTAL INSURANCE: We will be happy to process you insurance claim form electronically as a courtesy to you. If you have insurance, please be prepared to pay you portion of the total treatment fee on the day of service. Please understand that insurance policies vary greatly, therefore, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contract. As a service to our patients, we will bill insurance carriers on your behalf for the services performed. We will allow them 45 days to render payment. After 60 days, you are responsible for the remaining balance in full. Remember, you dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. If you have any questions about insurance information or are uncertain regarding coverage, please do not hesitate to ask us. We are here to help you.

SERVICE CHARGE
As a courtesy, we will bill your insurance company for you if provided with all proper billing information. Charges not paid at the time of service are due within 30 days. All accounts are due within 90 days, regardless of insurance involvement. A 1.5% *monthly finance charge will be assessed on all accounts past 60 days.* You will receive a monthly statement regarding amounts unpaid.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER
All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES
Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINOR PATIENTS
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 be

approved by Visa/MasterCard, American Express, Discover, Care Credit, The HELPcard or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS
Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee of $25 per hour for all cancelled or missed appointments without 48-hour notice.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian