

CONSENT FOR SERVICES, INSURANCE COVERAGE, FINANCIAL POLICY & HIPAA

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. We accept Cash, Check, Visa, Mastercard, Discover, American Express and CareCredit as forms of payment.

This office will submit the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. A missed appointment fee of \$50 will be applied if less than 24-hour notice is given.

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. We practice the standard of care, not allowing your insurance plan to dictate your overall oral health. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.

Signature: _____ Date: _____

Print Name: _____