

OFFICE GUIDELINES

CONSENT

I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before treatment is begun. If care is being rendered on a minor child, I authorize the doctor to obtain the x-rays and to treat the minor child as needed. I understand I will be given the opportunity to discuss the treatment plan with the doctor and that I as the parent/guardian, who accompanies the child to the office is responsible for payment.

FINANCIAL RESPONSIBILITY

1. Balances remaining beyond (90) days from first billing will accrue interest at the rate of 1 ½ % per month of the unpaid balance. (18% annual rate)
2. There is a \$25.00 charge for all returned checks.
3. Personal credit may be checked.
4. In the event of default, I promise to pay legal interest on the indebtedness, collection cost, and related attorneys' fees.

DENTAL INSURANCE

We are happy to file forms necessary to see that you receive the full benefits of your coverage, **HOWEVER**, We **CANNOT** guarantee any estimated coverage. Unless prior arrangements are made you **will be expected to PAY** the portion as services are provided. Please keep in mind that we can only **ESTIMATE** your portion. If there is a difference after your insurance company has paid, it is your responsibility to pay the difference. Because the insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over your claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits. Any balances not paid by the insurance company within 60 days of submission become the patient's responsibility to pay at that time.

PAYMENT OPTIONS

Cash or check: We are happy to offer a 5% pre-payment courtesy for treatment that exceeds \$100.00 and paid in full at time of treatment.

Credit Card: For your convenience, we have made arrangements to accept payment by several major credit cards as well as bank debit cards.

Interest free arrangements are available upon approval for long term financing. Applications are available and can be processed while you are in the office.

My signature will authorize assignment of insurance benefits to this office. By signing this form, I confirm that I have been offered a copy of the office Notice of Privacy Practices.

HIPPA

I understand that my information may be disclosed for Dental/Medical purposes

Signature _____ Date _____