



General Financial Agreement and Policy Acknowledgments

Patient Name(please print) _____

FINANCIAL AGREEMENT

It is your goal for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make dental treatment affordable to all our patients.

If you have dental insurance, we want you to receive the full benefit of it. Because we understand that dental insurance plays a role helping many people defray some of the costs of dental care, we would like to share with you the following information about dental insurance.

Please understand that our responsibility is to provide you with the treatment that best meets your needs, and not try to match your care to insurance plans limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered, even though you may need those services.

In spite of your plan says, we have found that many plans actually pay less than what you might expect. The benefits your plan pays are largely determined by how much you and your employer pay in premiums. Our office staff will assist you in completing your insurance forms and verifying the coverage that your particular insurance plan provides. We are happy to submit your claims and help you to receive the maximum benefits that you are due. We accept assignment of your insurance payment, but please understand that we cannot accept responsibility for collecting insurance claim, or for negotiating disputed claims.

Patient is responsible for any applicable deductible amounts and the portion of fees that your insurance does not over.

Please be advised that although our staff will make every effort to accurately estimate what your insurance will pay, this does not, in any way, guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedures rendered.

I have read and understand the above financial agreement. Regardless of the insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependants.

X _____
signature of patient, parent, or guardian date

GENERAL CONSENT

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment; a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminders sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

X _____
signature of patient, parent, or guardian date

APPOINTMENT POLICY ACKNOWLEDGMENT

When you (or a family member) make an appointment, you are responsible for keeping that appointment. Our staff will attempt to remind you of your appointment one or two days prior to the scheduled date. If you are unable to keep your appointment, we respectfully request 48 hours advance notice, and require 24 hours notice.

X _____
signature of patient, parent, or guardian date