Patient Financial Agreement and Treatment Consent

Financial Policy Agreement

1. **At your request, we can provide you an estimate** of charges, insurance benefits and your financial responsibility prior to scheduling your dental treatment. We recommend that you call your insurance company directly to check benefits and estimated cost.
2. **We ask that you pay for your estimated portion of treatment cost at the time treatment is provided.** If payment arrangements are needed, please make these arrangements prior to scheduling treatment.
3. **We will file your dental insurance claims for you** as a courtesy and will accept payment from your insurance company for the maximum portion they cover. You are responsible for the amount not covered by your dental insurance.
4. **Please notify us of any change** in your dental insurance benefit as soon as possible.
5. **We accept MasterCard, Visa and Discover**
6. **Any unpaid balance past due after 3 months** will be subject to an interest charge of 1.5% per month.

Consent For Treatment

I hereby authorize the doctor or designated staff member to take x-rays, study models, photographs and other diagnostic aids deemed appropriate and necessary for a thorough diagnosis of my dental health needs. I further authorize the doctor to perform all recommended treatment to which I have agreed, and to employ such assistance as required for safe and proper dental care. I agree to the use of anesthetics, sedatives and other medications as necessary.

Cancellation Policy

If you need to re-schedule or cancel a dental appointment, we require 24 hours notice so that the time reserved for you can be used by another patient. If adequate notice is not provided, we reserve the right to charge $50 for facility and staff costs.

My signature below indicates that I have read, understood and agree to the above conditions for dental treatment.

Signature_____ Date_____