

PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT AND RELEASE AGREEMENT

Dental treatment is an excellent investment in you and your family's health and wellbeing. We recognize that long range economy is of prime concern as well. The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT

- I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge
- I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier
- I authorize assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patient's initials _____

FINANCIAL RESPONSIBILITY

I understand that **PAYMENT IN FULL** is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. In situations involving large treatment plans, we provide the following payment options:

CASH, MONEY ORDER, CERTIFIED CHECKS, ALL MAJOR CREDIT CARDS. Returned checks will be charged a \$35 NSF fee on the patient account.

AFFORDABLE MONTHLY PAYMENT PLANS (SUBJECT TO APPROVAL). These are outside financing arrangements specifically designed for dentistry and related specialties - with AFFORDABLE MONTHLY payments via Care Credit.

- NO initial payment to Care Credit for approximately one month
- Low, fixed rates ranging from 4% - 12%
- NO prepayment penalty, terms up to 60 months
- Quick and easy application process with same day approval

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs/or any other expenses incurred in its collection as allowable by law.

CANCELLED AND MISSED APPOINTMENTS

I understand that if I find it impossible to keep a scheduled appointment, I must let the office know at least **48 hours** in advance so that another patient may use the time reserved for me. **We reserve the right to charge \$65 per hour for any missed appointment when not given 48 hour notice of cancellation/reschedule.**

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a COURTESY, we will submit the fees for your treatment to your insurance company on your behalf. However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment. We will attempt to gain as many benefits as possible from your insurance company; we are not a party to that contract. We accept assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient.

If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any "patient portion" not covered by insurance, which will be due at the time of service. Please be advised, this is an ESTIMATE and not a promise or guarantee of coverage from the insurance carrier.

RELEASE

I consent to clinical examination and the making of video, photographs, and x-rays before, during, and after treatment and to the use of same by doctor in scientific papers or demonstrations. In the event that the patient is referred to a specialist or other provider as part of their treatment plan, I consent to the office sharing necessary documentation including but not limited to x-rays and photographs so that the other provider can complete treatment.

PATIENT RECORDS

In the event that the patient leaves the practice and would like their most current x-rays sent to their new practice, the office will be more than happy to forward them via e-mail to the new provider. If the patient requests a full transfer of records, the office reserves the right to charge a processing fee of \$35. The office will forward the records via e-mail the most current x-rays and all chart notes to the requested destination.

Patient Signature: _____ Date: _____