Complete Dental
Where we Complete your Smiles

CONSENT FOR TREATMENT

I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Doctor to make a through diagnosis. Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payment is not received by agreed upon date, I understand that late charges may be added to my account.

PATIENTS WITH INSURANCE

While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Please keep in mind that your insurance plan is not designed to pay all charges but simply provides some assistance to you. Your dental insurance benefits are based upon a contract between your employer and the insurance company not our office.

We believe it is important to keep in mind that although an insurance company may state that their plan provides "100% or 80%"coverage for certain services, they do not specify the restricted fee they establish for these services of other actual limitations. These "usual and customary" fees are kept secret, have usually not been updated in many years, are not based on the average fees being charged by dentist in the area, and are not the same fees charged by us or in the office.

I hereby authorize payments directly to the dental office if the insurance benefits are paid to me. I understand that as a courtesy the dental office will assist me in processing my insurance claims; however **I am completely responsible for all fees in their ENTIRETY.** I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third payers.

In some instances, insurance companies and insurance checks directly to the patient. In these cases **PATIENTS ARE TO SUBMIT PAYMENT TO THE IMMEDIATELY.** We accept cash, Master**Card, Visa, Discover, American Express** & **care credit**. A fee of **$35** will be charged for **returned or bounced checks**.

In our office the parents who bring the child in for his/her appointment is the parent responsible for the payment. In divorce situations, any legal obligations on the part of either parent, to pay for dental treatment is to be worked out between the parents, not our office.

SCHEDULED APPOINTMENT

When an appointment is scheduled at the office, we reserve a dental suite just for you along with one-on-one time with the team member and doctor. For this reason, patients that cancel appoints without 24 business hour notice, or miss appointments may be subject to a reservation fee of $40 an hour that will be paid in advance of their reschedule appointment. I hereby acknowledge that I have read and accepted the Office Financial Guidelines and agree to all terms. **Signature:** _____ **Date:** _____