## Consent for Services and Financial Policy

Thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment for any treatment is **due at the time of service**. All patients must read and sign this for before seeing the Doctor.

As a condition of your treatment by our office, financial arrangements must be made in advance. Our practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

**Dental Insurance:** Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your treatment costs. Therefore, you will be expected to pay your **deductible** and your **estimated co-payment** on the day the services are rendered. We will gladly file your insurance claim as a courtesy. Many variables exits from insurance carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions) : therefore, **we can not guarantee any estimated charges.** Your policy and benefits are an agreement between you and the insurance company so ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. ***We will gladly file all dental claims for any given treatment. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.***

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information to secure the payment of benefits.

**I understand that I am financially responsible for all charges incurred for treatment whether or not paid by insurance.**

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Print Patient Name Date

_____ _____

Signature of Patient, Parent or Guardian Relationship to patient