WELCOME TO OUR OFFICE

We appreciate your selection of our office to serve your dental needs. Our staff operates as a team and we take great pride in each staff member's training. Our goal is to provide the very best possible dental care for our patients so that each of you may achieve optimal dental health throughout your lifetime.

OFFICE HOURS

Our regular office hours are from 8:30 AM to 5:30 PM Monday - Thursday. The office is closed on major holidays as well as times when the doctor and staff are attending continuing education programs.

FEES AND PAYMENT POLICY

In an effort to keep dental costs down while maintaining a high level of professional care, payment is expected at the time of service. For your convenience, we accept all major credit cards. Computerized insurance claims will be filed on your behalf, however, all deductibles and estimated copays are due at the time of service. Accounts outstanding more than 90 days from the treatment date will bear interest at 1 3/4% per month or 21% per annum. To avoid a broken appointment fee, please notify the office at least 24 hours before your appointment time. All major treatment, and treatment involving a laboratory procedure, will require an appropriate down payment.

INSURANCE

We work with most dental insurers. Carriers vary, but we will try to help you get the most benefit out of your particular policy. We will fill out your claim forms as a courtesy to you and answer any questions we can. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do ask that you pay your portion at each visit.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named herein and agree to pay all fees and charges for such treatment upon receipt of billing statement. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to myself or my family, I/we agree to pay collection fees, reasonable attorney's fees or other such costs as the court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

I also certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I, THE UNDERSIGNED, CERTIFY AND ACKNOWLEDGE THE FOLLOWING:

- I assign all third party payments to this practice.
- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other healthcare providers and institutions.
- I acknowledge that I have been offered a copy of the Practice's Notice of Privacy Practices.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.
- I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage.
- I assume responsibility for all the costs of collections, including financial charges, attorney fees and court costs.
- I understand that dental insurance companies rarely cover 100% of all dental expenses.
- I understand how my insurance company will pay for services rendered at this practice.
- I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized with the office two working days prior to the original appointment or a late cancellation fee may be charged.
- I have accurately answered all the questions and have read all the above information.
- I give consent for this practice to photograph any tissue, bone, or anatomical structures for purposes of diagnosis, treatment, patient education, presentation, or medical/dental research. I understand that any photographs or x-rays taken in this office may include identifiable facial characteristics.

Please inform us of the persons with whom we may share your health/dental/financial information:

Name: _____ **Phone** _____ **Relationship** _____

Name: _____ **Phone** _____ **Relationship** _____

SIGNATURE _____ **JOINT APPLICATION SIGNATURE** _____

(Responsible Adult)

(A copy of this assignment is as valid as the original.)