Authorization

I have reviewed this questionnaire and answered its questions to the best of my knowledge. I understand that the answers that I have provided will be used by the dentist to determine appropriate dental treatment for myself or my child. I agree to notify the dentist if any change in my health status or my child's may occur.

I authorize the dental staff to perform the necessary dental services that myself or my child may need.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist of dental group benefits otherwise payable to me.

I authorize the use of this signature on all insurance submissions and financial policies.

_____ _____

Signature of Patient or Guardian Date

Our Financial policy

Non-insured patients are expected to pay in full with cash, check, or credit/debit card the day the service is rendered.

For those who are covered by insurance, we will accept assignment of benefits. Most dental insurance companies do not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will ESTIMATE your coverage as closely as possible, but benefits are only an estimate, NOT a guarantee of payment…..Actual benefits will be determined by your insurance carrier as your claims are processed by them. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you, if insurance has not paid after 45 days the balance will be due from you.

A 1.5 % finance charge per month may be posted on any account that is 30 days past due. For those of you who pay your account monthly, we thank you. This finance charge will not affect you.

As of October 1st of 2018, patients cancelling appointments with less than 24-hour notice, or those who do not show up will be subject to a $50.00 inconvenience fee. We reserve your appointment slot just for you, please be courteous and confirm your appointment or let us know if you cannot make it.

Feel free to ask any questions that remain unanswered either before or after treatment. We wish to be of assistance if we can.

_____ _____

Signature of Patient or Guardian Date