

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon 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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

There will be a 50.00 charge for missed appointments or cancellations with 48 hour or less notice.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**I have read the above conditions of treatment and payment and agree to their content.**

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_

## Insurance and Financial Policy

At **Anderson Dentistry**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, here are some important things you should know:

**Please Initial:**

\_\_\_\_\_ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will usually not pay for all of your dental care. It is only meant to assist you.**

\_\_\_\_\_ ■ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of insurance payments by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your actual benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the out of pocket figures you may require.

\_\_\_\_\_ ■ We will bill your **primary** insurance as a courtesy. If insurance does not pay within 30 days, Anderson Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

\_\_\_\_\_ ■ **Anderson Dentistry** does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with **CareCredit**, who offers 3, 6, or 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

\_\_\_\_\_ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 48 hour** notice to avoid a **\$50 cancellation fee** (emergencies are an exception).

\_\_\_\_\_ ■ In the event of an emergency after regular business hours a **\$200 emergency fee** may be charged in addition to the necessary treatment fees.

**I agree with the above conditions.**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_