

Consent to Payment

Financial Arrangements

Our office offers simple financial arrangements in order to avoid possible misunderstandings. Unless prior arrangements are made, payment in full is expected at the time treatment is provided. We offer a 5% courtesy discount for full payment prior to beginning treatment. If the treatment is extensive or will take several months to complete, partial payment can be made at appointments over that time span. For your convenience, VISA, MasterCard, Discover and American Express are accepted. For more involved procedures, an interest-free loan (up to 12 months) can be arranged.

If you have dental insurance, we are happy to help you receive the maximum benefits you are allowed from your dental coverage. Please keep in mind that:

- ✓ Dental insurance benefits do not work in the same way as medical insurance. There is **almost always a co-payment** due from the patient for **almost every** procedure and we ask that you'll pay your portion at the time treatment begins. The co-payment is the difference between the treatment costs and the insurance payment.
- ✓ There are "**deductibles**" in all plans every year and you will be responsible for the deductibles every year
- ✓ Financial benefits cannot be saved and carried over into the next year. Your dental benefits almost always have a yearly maximum contribution level. This amount is the MOST your insurance carrier is contractually obligated to pay during a defined year (calendar or otherwise). When this amount is reached, there will be no further dental benefits payable until the next benefit year. If you have already begun some additional dental treatment prior to the maximum being reached, the insurance carrier has no payment obligation beyond that of the annual maximum.

Fee Guarantees and Nonpayment Procedures

The estimated fees we provide for dental services are guaranteed for 90 days. If treatment is not begun within 90 days of the estimate date, cost of dental treatment could vary. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. You will be informed if this occurs and given the option of continuing treatment, changing treatment, or canceling treatment.

If your balance becomes 60 days or more overdue, our office reserves the right to interrupt or discontinue dental treatment and/or send your account to an attorney for collection. In the event that your account is sent for collection, you will be responsible for all costs and fees, including reasonable attorney's fees, incurred. If payment is not made within 30 days, your account will be charged at a rate of 1.5% per month.

I consent to authorize the indicated dental services to be performed. I understand that at any time I may terminate or postpone the proposed treatment. I have been informed of treatment alternatives that relate to my oral conditions, their respective advantages and disadvantages, the substantial risks and consequences of limited or delayed treatment or nontreatment. I have been informed of the costs of the dental treatment and alternative dental treatment. I have been informed of financial arrangements available to me. All questions have been answered to my satisfaction and I have read and understand the above directions and cautions

Patient Name

Date

Patient Signature