Total Dental Care

RELEASE AND AUTHORIZATIONS

Authorization of Treatment: I present myself or child, for whom I am guardian, for the diagnosis of dental treatment needs. I will be notified of the procedures to be completed and authorize any emergency dental care.

Authorization for Release of Information: I authorize this practice to disclose all or any parts of the patient's dental record to listed insurance companies in order for my treatment to be covered by them. If I am referred to a specialist for treatment, I authorize this office to discuss my treatment in order to better serve me. I also understand that I may revoke this authorization by providing written notice to this practice.

Assignment of Benefits: I hereby authorize payment directly to this practice by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand that overpayment will be sent to the appropriate payor.

Insurance: The practice will file your insurance as a service to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We will estimate your benefits, but we must hold you responsible for any balance due.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me by the practice. I further understand that **payment is expected in full at the time of service**, unless financial arrangements have been made prior to my appointment.

Financial Arrangements: For your convenience our office offers financing for large treatment plans. I understand that all financing arrangements need to be made prior to my appointment. Please inquire with the front desk regarding our dental financing plan.

Notice of Privacy Practices: I hereby acknowledge that I have received a copy of the practice's Notice of Privacy Practices.

***Broken Appointments:** I understand that the practice requires at least a 24 hour notice to cancel or reschedule an appointment and that I may be charged a minimum of $50 for a broken appointment. I also understand that not giving at least a 24 hour notice could result in my dismissal from the practice.

Married or Dependent Patients: I hereby consent to the release of any patient-related or financial information about me to my spouse or other family member as follows:

_____ or _____ _____

Spouse's Name Name Relationship to Patient

Patient Name (please print) _____

Parent or Guardian (please print) _____
(if other than patient)

Signature _____ Date_____

Emergency Contact: _____ Phone: _____