AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

Patient Name: _____ **Date of Birth**_____

Taking care of you and your family is our highest priority. That is why, when it comes to finances, our goal is to provide you with clear information regarding our dental fees and your payment options. At the onset of treatment, we can provide you with an *estimate* of the total fees expected. Please understand that this will only be an ***estimate***. Treatment needs change for a variety of unforeseen reasons. Whenever possible, we will inform you of any treatment changes that will affect your financial estimate.

When estimating insurance coverage, we must also stress the word *estimate* as dental benefits are determined by each patient's dental contract. Every patient's dental plan is different, and necessary dental services are not necessarily covered. Most dental plans are designed to ***assist*** patients with their dental expenses. Very few dental plans fully cover all dental services. If you bring in a copy of your dental plan, our staff will be happy to help you interpret your dental benefits. Without a copy of your dental plan, only an ***estimate*** can be provided based on what a "typical" dental plan provides. If your dental plan pays more than expected, you will receive a prompt refund. If your dental plan pays less than expected, a balance due will be reflected on your monthly statement. If your dental plan later determines that you were not eligible for coverage, the balance becomes your responsibility.

I agree and understand that I am financially responsible for all charges incurred for dentistry performed upon me and my dependents, whether or not they are paid by insurance. I agree to pay all deductibles, copays and for all non-covered services at the time of service. Any insurance claim not paid in full after 60 days will become my responsibility at that time. Financial options and payment arrangements may be approved prior to treatment for patients who want to make short term monthly payments.

A 1.5% interest charge will be applied to that portion of the account which is not received 30 days from the statement date. Payment is due in full within 90 days. If my account becomes delinquent, I agree to pay for all the collection costs which may include attorney fees and court costs. Collections costs currently range from 28% to 40%.

I hereby authorize and request my insurance company to assign benefits directly to my dentist otherwise payable to me. If my current policy prohibits direct payment to the dentist, I hereby agree to pay the dentist the sum equal to the insurance payment received by me.

I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Patient's Representative/Guardian Date: