

CONSENT FOR TREATMENT

I hear by authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complication. I understand that I will be informed of any anesthetic, sedative or any other medication prior to dispensing.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health record that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available. I will be given the HIPAA forms to read and sign.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5 % late charge (18% APR) may be added to my account.

Patient / Parent / Guardian Signature (please circle) **Date** **Witness**

ASSIGNMENT OF INSURANCE BENEFITS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless prohibited by law, or by treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with a claim.

Patient / Parent / Guardian Signature **Date**

I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Policy Holder/Subscriber of Insurance **Date**

FINANCIAL OPTIONS

All treatment is to be paid at the time of service, unless insurance is involved and therefore your ESTIMATED CO-PAY is due at the time of service.

We offer as payment options: CASH, CHECK, MASTERCARD, VISA, DISCOVER

ASK US ABOUT OUR NO INTEREST PAYMENT PLANS THROUGH CARE CREDIT

OVER 

Financial Policy

Thank you for choosing Knowlton Dental Associates as your dental care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions about our financial policy, please do not hesitate to ask.

Payments: Unless other arrangements are approved by us in writing, the balance on your account is due and payable when services are rendered.

Dental Insurance: If we do not participate with your insurance, payment in FULL is required at the time of service. Dental insurance is a contract between you, your employer and your insurance company. We are NOT a party to this contract unless your insurance is through Cigna PPO, Delta Dental PPO, GEHA, and anything in the Connection Network. If you have one of these policies, **we ask that you pay your estimated portion at the time of your appointment.** For *all* other insurances, full payment is due at the time of the visit and as a courtesy to you, we will submit a claim on behalf to your insurance company and they will provide reimbursement directly to you.

IMPORTANT: Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility and payment received. Payment from your insurance is never a guaranteed. We recommend that you understand your insurance policy; its limitations and benefits.

Please initial that you have read and understand the above statement _____.

Missed Appointment Fee: We make every effort to schedule appointments at your convenience and also confirm your appointment in advance. We do require at least 24 hours notice (one business day) if you are unable to keep your appointment. If you fail to make your appointment you will be charged \$75.00 cancellation fee. *This fee must be paid before another appointment is scheduled.*

Please initial that you have read and understand the above statement _____.

Payment Options:

- You may choose to pay by cash, check, or credit card.
- We accept Visa, MasterCard, American Express and Discover.
- We also participate with Care Credit. They offer several financing options, some of which are interest free

Past Due Accounts: Any accounts over 90 days are automatically referred to a collection agency or reported as delinquent to the credit bureau. You agree to pay all costs which are incurred as a result of these actions. Accounts over 30 days will incur an 18% monthly finance charge unless other arrangements have been made.

Returned Checks: There is a \$50.00 fee for any checks returned from the bank.

By signing this agreement, you understand and agree to all the terms and conditions contained herein and realize this agreement will be in full force. All questions were answered to your satisfaction.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to call us so that we can assist you in the management of your account.

Again, thank you for choosing Knowlton Dental Associates for your dental care. We appreciate your confidence in us and the opportunity to serve you.

Name of person Responsible for Account: _____

Relationship: self _____ parent _____

Signature: _____ **Print Name:** _____ **Date:** ____/____/____

Staff Signature: _____ **Print Name:** _____ **Date** ____/____/____