



DC Perio & Implants

PLLC

Financial Consent

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. **I understand that the estimated cost is only an estimate and it is not based on exclusions and limitations that your policy may have in place in which the DC Perio and Implants, PLLC is not privy to.** I understand that it is **my obligation and duty** to find out what **my total out of pocket expense** will be for any dental procedure as DC Perio and Implants, PLLC can not provide me with a guarantee of payment from any insurance company. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 60 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a \$50 returned check fee. Any account balances that remain unpaid for 120 days from the date of service shall accrue interest at the rate of eighteen percent (**18%**) per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of **\$85**. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith. I understand that a broken appointment fee is **\$175 per hour** for surgical and **\$85 for non surgical if I do not cancel my appointment in 24hrs**.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: _____ Date: _____

Print Name: _____

Guardian/Responsible Party, if minor: _____ Date: _____

Print Name: _____