BROTHERS DENTAL

Caring Family Dentistry

Patients Name: _____

Consent for Services and Financial Policy Notice

I understand that there is a strict 48 hr notice needed for any dental reservations to be changed to avoid a $50 per hour charge on my account. This will need to be paid before any more reservations can be made.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their case. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without financial arrangements, must be paid in cash/check or credit card at the time services are preformed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the insurance company for payment. We will provide an estimated Co-payment at the time of service. This copayment is Due at the time of service per the insurance rules/policy. If the insurance company reimburses the Doctor less than expected, the patient is legally responsible for ALL dental charges that are incurred. I allow to Release my authorization for Reimbursement from my insurance company to pay the office directly.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months maximum from the date of the patient's examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within (5) business days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to , by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ By initialing this box, I understand the above information and agree with its contents. This will serve as a signature for the online Administration Form.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will be affected if I refuse to sign this form.

I Understand that information used or disclosed, pursuant to this authorization, could be subject to re –disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I HAVE READ AND AGREE TO ALL THE ABOVE INFORMATION - BY SIGNING THIS FORM

Patient/Guardian Signature: _____ Date: _____