TOTEM LAKE SMILES

PATIENT NAME: ____

CONSENT FOR SERVICES

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and authorize the administration of anesthetics and x-rays as may be deemed necessary by the doctor in the course of treatment.

Signature: ______________________________ Date ________________

Relation to Patient (if different) ______________________________

FINANCIAL POLICY & INSURANCE AGREEMENT

Payment is required at the time of treatment. We offer the following methods of payment: Visa, MasterCard, Discover, cash or check. Our office does offer a 3- or 6-month payment plan, depending on the treatment needed. An extended payment plan is available through CareCredit, an outside lender. Please inquire with our office staff for more information. All payment arrangements must be made prior to the date of service.

A 5% discount will be extended to patients without insurance coverage who pay in full at the time of service.

Insurance

If you have a dental insurance plan, we will submit your claim forms and apply any payments received to your account. Your insurance company will provide benefits according to the provisions of your particular policy. It is in your best interest to understand your own insurance plan and any limitations it may have. In this regard we would like to offer the following tips:

- Please provide our office with your insurance card prior to your first visit, and let us know of any subsequent changes. If your plan pays by a fee schedule, please provide us with that schedule.
- We will gladly submit a pre-treatment estimate to your plan upon request. All charges and insurance payments are subject to change based on unforeseen circumstances, which may alter your final amount due.
- Remember that most plans only pay a portion of your treatment costs. You, the patient, are responsible **in full** for any amount not paid by your insurance.

Missed/Cancelled Appointments

Our office will provide you with complimentary appointment reminder emails and/or texts prior to any appointment. Should you need to reschedule an appointment we require **24 business hours** notice to avoid a fee. We understand extenuating circumstances arise, so please let us know ASAP if this happens.

Your signature below signifies you have read and understand our office policies. A copy will be kept in your records.

Thank you!

______________________________ ________________

Patient/Guardian Signature Date