FINANCIAL POLICY

We welcome you to our family of dental care providers and we are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept cash, checks, Visa, MasterCard American Express, Discover or we offer the Norwest payment plan, which allows low monthly payments with prior credit approval.

Please indicate the method of payment you wish to choose to settle your account:

- ☐ Cash or Check
- ☐ Visa or MasterCard
- ☐ Discover
- ☐ American Express
- ☐ Care Credit/Chase Financial

Regarding Insurance

We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have complete insurance information and confirmation of your coverage. It is your responsibility to fill the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 45 days of billing, the balance becomes your responsibility. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise.
We expect all balances to be cleared in less than 45 days.

Usual and Customary Rates

Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing

For all accounts over 45 days with patient amounts due, there will be a $10.00 billing fee or a finance charge of 1.5% per month, whichever is more. We assign all accounts over 120 days to a collection service for processing.
There will be a charge of $50.00 for canceling a general dentistry appointment, and $75.00 for canceling a specialty appointment without 24 hours notice or for failing an appointment.

Should this account become past due, you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs, necessary to collect this amount.

I agree to this financial policy, and I have read and received a copy of this statement.

_____ Date_____
Patient or Parent/Guardian Signature

_____ Date_____
Staff Signature

CONSENT TO TREATMENT

TREATMENT TO BE DONE- I understand and consent to have any treatment done by the dentist after the procedure, the risks, the benefits and the costs have been fully explained. These treatments include, but are not limited to, x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, and/or dentures.

DRUGS AND MEDICATION- I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

CHANGES IN TREATMENT PLAN- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

REMOVAL OF TEETH- I understand that there are alternatives to tooth removal(root canal therapy, crowns, and periodontal surgery, etc.) and agree to completely understand these alternatives, including their risks and benefits prior to authorizing the Dentist to remove teeth and any others necessary for reasons as above. I understand removing teeth does not always remove all the infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my resposibility.

CROWNS (CAPS) AND BRIDGES-Preparing a tooth may irriate the nerve tissue in the center of the tooth, leaving your tooth feeling sensitive to heat, cold or pressure. Treating such irritation may involve using special toothpastes or mouth rinses or root canal therapy. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is my responsibility to return for permanent cementation within 20 days from tooth preparation, as excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation, and I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before permanent cementation.

ENDODONTIC TREATMENT (ROOT CANAL)-I understand that there is no guarantee that root canal treatment will save a tooth, and that complications can occur from the treatment, and that occasionally root canal filling materials may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and drills are very fine instruments and stresses vented in their manufacture and calcifications present in teeth can cause them to break during use. I understand that referral to an endodontist for additional endodontic treatments may be necessary following any root canal treatment, and I agree that I am responsible for any additional costs for treatment performed by the endodontist. I understand that a tooth may require extraction in spite of all efforts to save it.

PERIODONTAL DISEASE- I understand that periodontal disease is a serious condition causing gum and bone inflammation and/or loss and that I can lead to the loss of my teeth. I understand the alternative treatment plans to correct periodontal disease, including gum surgery, tooth extractions with or without replacement. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

FILLINGS- I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling or crown may be required, as additional decay or fractures may become evident after initial excavation. I understand that significant sensitivity is a common, but usually temporary, after effect of a newlyplaced filling. I further understand that filling a tooth may irritate the nerve tissue creating sensitivity and treating such sensitivity could require root canal therapy.

DENTURES- I understand that wearing of dentures can be difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. I understand that it is my responsibility to return for delivery of dentures. I understand that it is my responsibility to return for the delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays or more than 30 days there will be additional charges. A permanent reline will be needed later, which is not included in the denture fee. I understand that all adjustments are included in the denture fee for a period of six months from the date of the delivery, and that any and all adjustments or alterations of any kind and after this intial period are subject to charges.

ORTHODONTIC TREATMENT (BRACES)-I understand that sore teeth, inflamed gums and canker sores are common problems to orthodontic treatment. I understand that treatment time may be lengthened from the original estimate due to the severity of the problem, patient growth, or the level of patient cooperation; if this is the case, additional fees may be assessed. I understand that the risk of cavities, enamel decalcification and periodontal disease is greater with braces, and so meticulous oral hygiene must be practiced. I understand that root resorption is possible during orthodontic treatment, and if this is detected, braces may be prematurely removed. I understand that ideal results may not be possible due to bone structure, missing teeth, shape and size of teeth, and growth. I understand that retainers will be required after treatment to keep teeth straight, but minor relapse may still occur. I understand that adjunctive dental treatment such as restorative dentistry, extraction of teeth, periodontal or oral surgery may be necessary during orthodontic treatment; this additional treatment is not included in the orthodontic fee.

I understand that dentistry is not an exact science and that no dentist can properly guarantee results.

I herby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is subject to modification depending on unforseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fee, or court costs that may be incurred to satisfy any obligation to this office.

_____ Date_____

Patient or Parent/Guardian Signature

_____ Date_____

Doctor Signature