A Word About Finances

We are committed to providing you with the best possible dental care. In order to achieve this goal, we need you assistance and understanding of our policies.

For your convenience we accept cash, checks and all major credit cards.

Assignment and Release:

I, _____ the undersigned, have insurance with _____, and assign directly to Dr. Warn all benefits, if any, otherwise payable to me for services rendered. **I understand that my insurance is a contract between my employer, my insurance company and myself. I understand that Dr. Warn is NOT a party to that contract and that I am fully responsible for all charges whether or not paid by insurance.** I understand that not all services are covered as a benefit in all contracts and that some insurance companies arbitrarily select certain service they will not cover. I understand that, as a Courtesy, my insurance claim will be filed for services and my **estimated co-payment** and any deductible is due at the time of services. I understand that if there is any remaining balance after the insurance company has paid, a statement will be sent to me for payment. I hereby authorize the doctor to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurances submissions whether manual or electronic

Date_____/_____/_____ Signature_____

Minor/Child Consent

I, being the parent or guardian of _____, do hereby request and authorize the dental staff to perform necessary dental services for my child including, but not limited to, X-rays and administration of anesthetics deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

Date_____/_____/_____ Signature_____

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. **I accept full responsibility for ALL charges incurred.** I have read and understand these policies and agree to be financially responsible for my dental treatment as described.

Date_____/_____/_____ Signature_____

Brett R Warn DDS, 5103 NW Cache Road Lawton OK 73505 (580)-248-4224