Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CONSENT OF SERVICES***

INSURANCE

The percentage of what insurance does not pay is DUE TODAY

Patients who carry dental insurance understands that all dental services will be filed on his/her insurance and that he/she is personally responsible for payment of their estimated dental services. This office will prepare the patients insurance forms and assist in making collections from the insurance companies and will credit any such collections to the patient’s accounts. The dental office cannot render services on the assumptions that our charges will be paid by an insurance company***. If insurance does not pay for the dental services(s), then you, the responsible party will be responsible for the total services.***You will owe a percentage of what your insurance does not pay today.

Please let us know how you will paying for today’s services

\_\_\_\_\_\_\_\_Cash \_\_\_\_\_\_\_\_check \_\_\_\_\_\_\_\_credit card \_\_\_\_\_\_\_\_Care credit (you may get information about this at the front desk)

\_\_\_\_\_\_\_\_Medicaid/ARKIDS

NO INSURANCE

Payment is due TODAY

Please let us know how you will be paying for today’s services

\_\_\_\_\_\_\_\_\_\_Cash \_\_\_\_\_\_\_\_\_\_check \_\_\_\_\_\_\_\_\_\_Credit Card \_\_\_\_\_\_\_\_\_\_Care credit (You may get insurance about this at the front desk)

As a condition of your treatment by this office, financial arrangements must be made in advance with the doctor. The practice depends upon reimbursement from the patients for the cost incurred in their care. All emergency dental service, or any dental services performed without previous financial arrangements, must be paid for in payment type above at the time services performed.

If future treatment is needed after today’s visit, I understand the fee estimate listed for dental care will only be extended for a period of six months from the patients exam, pricing may raise due to the increasing rate of dental cost.

I grant my permission to you or you assignee, to telephone me at home, work, or other to discuss matters related to this form

I have the above conditions of treatment and payment and agree to the content

***SIGN BOTH***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of patient, parent or guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of responsible party