



## CONSENT

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT FORM** It is your dentist's responsibility to recommend what you need. All recommendations are based on diagnostic (x-rays) and clinical pictures and presented to you by the dentist. We will give you options (if any) for the treatment recommended, answer all questions you might have about it and will help you to decide what treatment would be the best for you. A Treatment Coordinator will go over any financial arrangements with you as needed.

When your office visit is completed, you will be asked to pay an estimated amount for the service provided. Our estimate is a guess based on the information provided by the insurance representative over the phone. The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.

**INSURANCE:** As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible to know your Plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as a missing tooth, crown/ bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exams, prophylaxis, fluoride and x-rays etc.

The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, or Discover. To help you accept an extensive treatment plan, we are offering a CareCredit dental treatment Financing Program. All estimates are subject to final approval by your dental insurance plan; therefore the amount due is subject to change after final explanation of benefits have been paid.

**FINANCIAL CHARGES:** All returned checks are subject to a \$25 fee. All balances over 90 days are subject to interest in the amount of 1.5 % per month mandated by State law.

**PAST DUE ACCOUNTS:** In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees.

**MISSED APPOINTMENT FEE:** Please note that there is a missed appointment fee of \$50.00 for all appointments not given at least 24 business hours notice. Please give us a call in advance if you need to reschedule or cancel your appointment.

This is an Agreement between Shorewood Family Dental Care, as a provider of professional services, and the Patient named on this form. By reading and signing this Agreement, you are agreeing and accepting this Policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF SHOREWOOD FAMILY DENTAL CARE.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_