Release / Consent

A. I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental Disease or treatment of dental emergencies. These procedures may include radiographs, models and intraoral examination. In the case of dental emergency, I consent to treatment as deemed as necessary by the doctor, understanding that the procedures will be explained in advance.

B. I give consent to the use of local anesthetics and relaxants for completing the necessary dental treatment.

C. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

D. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

E. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payments in full for all accounts of services provided.

F. I understand that a 24 hour business notice via telephone is expected for all needed cancellations. A fee of 25$ per hour of time reserved for an appointment time may apply if the 24 hour notification by telephone to the office is not given.

G. I attest to the accuracy for the information of these pages. I understand that it is my responsibility to inform The Doctor and the office staff of any changes in my medical status at the very next appointment, before any further treatment is rendered.

H. I have either been given the opportunity to review or instructed on how/where to receive a copy of the HIPPA paperwork.

Financial Policy:

Payment- We require payment in full at the time of service. For your convenience we accept cash, personal checks, Visa, Mastercard, Discover and American Express. We also offer and accept payments via Care Credit. Prior to service, we will review with you the treatment that will be competed along with your patient responsibility. Please understand that payment of your bill is considered part of your treatment, and you will be required to make any financial arrangements prior to any work being performed.

Submission- As a courtesy we will prepare and submit your insurance forms for reimbursement if we have been given all necessary information for submission. We cannot bill your insurance company unless you bring in all your insurance information . Please keep the following in mind:

- The balance is your responsibility whether your insurance pays or not.
- Your insurance policy is a contract between you and your insurance company. We are not a party to contact.
- Please be aware that some and perhaps all of the dental services performed by Northern Smiles Family Dental May be "non-covered" services and not considered reasonable and necessary under your dental contract.

Patient Portion: Your patient portion will be estimated and due on the day of service. This estimate is based on Information received by our staff form your insurance company and is only an approximated amount. patient portions which are under estimated will be billed immediately after payment is received from your insurance company. Checks which do not Clear with your bank will be assessed a $25.00 service charge for reprocessing. Once a check does not clear your account, it will no longer be considered as an acceptable form of payment.

I have read the above, and do understand and agree to the Financial, Release and Consent policies.

_____ _____

Patient or Guardian Signature Date