Financial Policy and Consent

We feel that all patients deserve from us the best dental care we can provide, and further, we feel that everyone benefits when office policy and financial arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our office policy. **We accept cash, personal check, cashier's check, money order, Visa, MasterCard, Discover and American Express. We also offer alternative payment plans (based on approval) as an option for financial arrangements.** As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. This office, as a courtesy, will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company, not the dentist.

This office is NOT in-network with ANY dental insurance company, PPO or DMO plan.

There is no guarantee of insurance coverage for any procedures. You are expected to pay when services are rendered unless prior arrangements have been made. We will file your insurance as a courtesy to you, but it is your responsibility to follow up with them if you do not receive payment. As a courtesy to you, our staff will assist you with any conflicts you may have regarding your insurance but cannot guarantee the outcome. However, should questions arise, it is best to contact your insurance company directly first then call our office if need be.

I hereby authorize Wayne S. Scott, D.D.S., Julie W. Scott, D.D.S., and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I authorize Dr. Wayne or Julie Scott and/or any other qualified assistants of this practice to release information necessary to other physicians, specialists or dental providers as needed for my care.

I understand that if I miss an appointment or do not give 24 hours notice to cancel or reschedule my appointment that a $55 fee will be charged to my account and payment will be due immediately.

I understand that the fee estimate provided to me for dental care can only be extended for a period of 90 days from the date of examination.

I grant my permission to you or your assignee, to telephone me at home, work or cell to discuss matters related to this form. I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same. I authorize insurance benefits to be assigned to the doctor if prior arrangements have been made. To the extent permitted under applicable law, I authorize release of any information relating to the proposed treatment or services rendered to my insurance company.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party