

## Financial & Office Policies 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. **We accept cash, personal 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.

**Patients who carry dental insurance understand that all dental services furnished are filed only as a courtesy and that the patient is personally and financially responsible for payment of all dental services/fees not paid by the insurance company.** This office will help prepare and file the patient's insurance forms and will assist in making collections from insurance companies. However, insurance companies have a wide variety of rules, exclusions, and plan limitations that our office may not be aware of, as the information given is limited. 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 our office.

**This office is NOT in-network/contracted with ANY dental insurance company or plan.**

There is no guarantee of insurance coverage for any procedures. You are expected to pay any estimated out-of-pocket expense/co-pay when services are rendered unless prior arrangements have been made. As a courtesy to you, we will assist you with any conflicts you may have regarding your insurance but cannot guarantee the outcome.

I hereby authorize Wayne Scott, D.D.S., any and all associate doctors, 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 this practice to release information necessary to other physicians, specialists or dental providers as needed for my care.

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 phone 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 agree to verbally confirm my appointments (through phone call, text, or email) within 24hrs of my scheduled appointment time or my appointment will be canceled with the \$75 per hour fee applied. I understand that if I am more than 10 minutes late to my appointment, my appointment may need to be rescheduled. I understand that if I miss an appointment or do not give 24 business hours' notice to cancel or reschedule my appointment, that a \$75 per hour fee will be charged to my account and must be paid prior to rescheduling. Multiple occurrences of late cancellations/no-shows will result in being placed on a "same day only" appointment status, or being dismissed from the practice.**

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Name of patient, parent or guardian

\_\_\_\_\_  
Name of guarantor of payment/responsible party

\_\_\_\_\_  
Signature of guarantor of payment/responsible party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date