FINANCIAL POLICY CONSENT FORM

We welcome you and your family to Precision Implant Care. We look forward to providing you with top-notch quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your treatment as much as possible.

You need to be aware that:

- You are required to pay for your treatment, in full, at time of service. Insurance payments are not accepted as a portion of payments.
- We will always do our best to help you to maximize your insurance benefits.
- Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract and can make **no** payment guarantees.
- Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.
- Not all services are covered benefits in all contracts. We cannot act as a mediator with the carrier or your employer.
- As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described. If your account is referred to an outside collections agency, you will assume responsibility of all accrued fees.

Refund Policy

Refunds are given ONLY for treatment that was not completed.

Deposit Policy

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for surgery appointments, we require a deposit of half of the treatment fee to make your reservation.

Rescheduling/Change in Schedule Policy

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other clients. If proper notice is NOT received, the deposit left for the scheduled surgical appointment will not be refunded or returned.

I _____ have read and agree to the Financial Policy and the Cancellation Policy of Precision Implant Care. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Print Name:_____ **Signature**_____ **Date**_____