Capital City Dental: Consent for Services

It will be helpful for you to know how the business aspects of our office are handled. To help you receive the best care, we ask that you spend a few minutes learning about our office policies. Our office is opened to ages 3 and up for the practice of General Dentistry. When necessary, you will be referred to a specialist who will bill you directly. Our business and clinical hours are 8:00 am to 5:00 pm Tue – Thur. and Friday 8am to 3pm. For your convenience, we have Voice Mail to take your messages if we are unable to take your call.

**ALL APPOINTMENTS ARE REQUIRED TO BE CONFIRMED. As a courtesy, we attempt to contact you via electronic sms and/or e-mail for confirmation of the scheduled appointments. However, should you not confirm your appointment by 2pm the day prior to your appointment the appointment will be vacated. If you cancel an appointment without a minimum of 24-hour notice, or you don't show for an appointment, a minimum fee of $50 will be accessed to your account. Three (3) such occurrences may result in your termination as a patient.
Late arrivals for a scheduled appointment are not always able to be seen by the provider due to courtesy to our other patients. A late arrival fee of $50 or a portion of the treatment fee may be assessed. Repeated late arrivals may result in your termination as a patient.**

Initial_____________

Patients with dental insurance (all patients with dental insurance, please read thoroughly):

1) Please understand that all dental services furnished are charged directly to the patient and he/she is personally responsible for payment of all dental services. Insurance is billed as a courtesy to all our patients. Every attempt is made to determine the exact amount that your insurance will cover for any procedure however, the final responsibility for payment rests with the patient. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Your estimated portion is always due at the time that treatment is rendered.** I understand that the fees and *estimate* listed for dental care can only be valid for a period of three months from the date treatment was diagnosed.
2) Please understand that our number one concern is to treat you with the most advanced materials and services available to improve the outcome and longevity of a healthy smile. Dr. Horgan has set a standard of care used in our office through his years of education and experiences. **Our standards and material choices will not be dictated by an insurance company.** Every dental insurance company operates differently and some have exceptions and exclusions for materials or procedures. If materials or services are rendered that are beyond what an insurance company provides for, **you as the patient will be held financially liable for such services.** It is the responsibility of the patient to understand what their particular insurance plan coverage contains. We will happily provide insurance and patient portion estimates for all procedures advised if asked for. However, please understand these are estimates only and it is the patient's responsibility to accurately obtain plan coverage from their personal insurance plan. **We do not have the time or resources to be responsible to know exactly what each and every insurance plan will cover in each instance. This responsibility belongs to you the patient and your insurance provider.** If you are concerned please ask that all work be pre-authorized through your insurance company to give you a better estimate if needed.
3) I assign directly to Capital City Dental, Dr. Horgan, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

<u>Payment in full is expected at the time of the service.</u> For crowns, dentures, partials, and prosthesis, your portion, not including estimated insurance payment, is due in full at the time impressions are taken. **Patient portions 60 days past due will be charged a finance fee of 18% per annum.** In case of unpaid balances, collection agencies and small claims courts are used. Additional fees up to 45% and /or court cost are added to the account balance. This is easily avoided by communicating with the office if there is a problem.

To facilitate payment we accept Visa, Master Card, American Express and Cash. On approved credit, you may make financial arrangements through Care Credit. Applications are available at the front desk. Financial arrangement other than those stated above must be made prior to the appointment. Any patient balance over 60 days will be charged a monthly interest rate of 18% per annum. The policies are no reflection on your personal credit and we do appreciate your understanding and cooperation. Patient credit balances remaining on their account will if within 1 year be returned or over 1 year will be exchanged for future dental treatment. If a credit card was used to obtain the credit balance a charge of 10% will be assessed on the credit balance prior to patient refund.

I have received or read a copy of this office's Notice of Privacy Practices. I also grant permission for Capital City Dental to discuss my dental treatment or other aspects of my dental care with ________________________________.

In consideration for the professional service rendered to me by the Dentist, or at my request, I agree to pay the value of said services to the Dentist, or the assignee, at the time the services are rendered. I further agree that the reasonable value of services shall be billed unless objected to, by me in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver term or condition and I further agree to pay costs and reasonable fees if suit were instituted hereafter.

I grant my permission to you or your assignee, to text, telephone and/or e-mail me regarding dental related matters.

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

________________________________Date:__________________Relationship to Patient:______________________________
Signature of patient, parent or guardian