

DeCino Family Dentistry

FINANCIAL / GENERAL CONSENT

- We invite you to discuss with us any questions regarding our service and/or recommended services. The best dental health is based on a friendly, mutual understanding between provider and patient. We are more than happy to reserve an individualized time to discuss any concerns or questions you may have before/after services are rendered or recommended.
- As a courtesy to us and to respect time, please call us 48 hours in advance if you are unable to keep an appointment. If you are running behind more than 15 minutes, please understand we may choose to do as much as reasonable in the remainder of your appointment, or reschedule your reservation. This is in effort to respect the time of the next reservation.
- Policy requires payment in full or estimated patient portion if insurance is involved, for all services rendered at the time of service. We accept VISA, MASTERCARD, DISCOVER, CASH and/or CHECK. We also provide payment options such as CareCredit and our DeCino Family Dentistry Dental Assistance Savings Plan. We will do our best to work with you. If your account is not paid within 60 days from time of service, efforts will be made to reconcile the account balance in a timely manner. Upon no reconciliation, or financial agreement, at 90 days you will be responsible for any additional billing fee up to \$5.00 a month. At 120 days you will be responsible for legal fees, collection agency fees, interest fees, and any other expense incurred in the collection of your account.
- As a courtesy to you, we will file claims with your insurance company, if possible. If insurance information is not available at the time of service, full fee-for-service will be expected and collected and any insurance payment will go to you, either direct or reimbursed.
- It is always advantageous to you, and to us, if you are familiar with your insurance plan/company. We will recommend the best treatment for you regardless of whether you have insurance or not. Every insurance company and plan is different, and it is impossible for us to know the details of every plan. The insurance will always release more information to you than they will to us. Estimates are always given as an estimate. Ultimately, your insurance is your responsibility and we will not be held responsible for obtaining certain information that is inaccurate.
- I understand that it is my responsibility what facilities and providers are in my insurance plan/company. We may offer referral information, and I understand that there may be different policies (insurance, payment, office, etc.) and guidelines associated with a referral. I will take those incidentals which are associated with this third party and have no association within our office.
- I authorize assignment of my insurance rights and benefits directly to the provider, aside aforementioned, for services rendered.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment with my consent or refusal. I also understand that there may be more than one option available for treatment. I expect to be given all options and will sign a treatment consent authorizing treatment. I will also be given the risks of certain treatment, or lack thereof, explained to me.
- I understand my medical history may be completed electronically and may require an electronic or physical signature, stating all information is complete and accurate. We will not be held accountable for inaccuracy.
- I authorize the provider to release any information to insurance, referral provider or authorized personnel with accordance to HIPAA.

Signature of Patient/Parent/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____