FINANCIAL POLICY/CONSENT FORM

In order to avoid any confusion about the payment options of this office or the utilization of your dental insurance, we have assembled an outline to help answer any questions you may have.

PAYMENT POLICY:

- **Payment is due when services are rendered**
  We accept:
  - CASH OR CHECK
  - VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER
  - FINANCING AVAILABLE THROUCH CARE CREDIT
- We DO NOT have an open account system of payment

INSURANCE POLICY:

- We are happy to accept your dental insurance and work with you and your insurance company.
- We will complete and mail/electronically file your insurance forms.
- We will compute an **estimate** of your percentage of payment at each visit; this payment is due at the time when services are rendered.
- Any questions concerning the reasoning behind insurance payments should be addressed to either your employer or insurance company.
- Our office has no written contract with your insurance company. The contract is with the patient and the insurance carrier. As such, this dental office has no legal recourse against your insurance company—as per Mississippi State Insurance Commission, should we encounter difficulty in collecting payment.
- If your Insurance Carrier has not paid on your claim within 60 days, we reserve the right to request payment by the patient. (This policy is in place to "weed-out" slow paying insurance companies.)
- Please remember that the final responsibility for any balance due rests with the patient.

If we can be of any assistance please let us know. We will be glad to help you.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other Dentist other than the treating Dentist nor _____ is responsible for my treatment.

I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make all/any changes and additions as necessary.

I hereby acknowledge that I have read and understand the above listed office payment policy and insurance payment policy. I further agree that in the event this amount becomes delinquent, I will be responsible for finance charges, all attorney fees and court cost.

_____

PATIENT SIGNATURE

_____

WITNESS SIGNATURE