Consent for Treatment and Office Financial Policy

Consent for Treatment

1. I hereby authorize Richard M. Jones, DDS or any designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____ 's dental needs. X-rays, study models and photographs are for the use by and property of Dr. Jones.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetics embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Office Financial Policy

1. Patients and/or their account holders are financially responsible for payment of all services rendered. Our office policy requires payment at the time of service unless other arrangements have been determined in advance of treatment date.

2. **Dr. Jones is an out-of-network provider, meaning that in some cases, there may be a difference in the benefit amount that an insurance carrier will pay when compared to an in-network provider. Our office can send a Pre-Determination to your insurance carrier to help determine your insurance benefits available out of network.**

3. As a courtesy, our office will file any applicable dental insurance claims for you and your dependent(s). Our office will request assignment of benefits from your carrier, in most cases. When treatment is provided, patients will be asked to pay an estimated amount towards their out-of-pocket cost. **It is important that patients understand that our office cannot estimate the exact amount of any benefits payable by any insurance carrier.** We highly recommend, and in some cases will require a Pre-Treatment Estimate or Pre-Determination be submitted on your behalf to your insurance carrier prior to treatment, as this is the best way to know for certain what benefits your policy covers and the resulting cost to you. **Patients are financially responsible for any and all amounts not paid by their insurance company.** In the case that your insurance company should pay more that estimated, resulting in a credit balance, you will be promptly reimbursed.

4. Our office may charge for failed or canceled appointments (without the required 24 hours notice), according to the fee schedule listed below;

   Dr. Appointments charged at a rate of $50 for every ½ hour of scheduled time missed.
   The fee for a failed appointment with a hygienist will be $50.

My signature below confirms that I have read, understand, and agree to the Consent to Treatment and the Office Financial Policies listed above.

Patient name (print) ____________________________________

Parent or Responsible Party (signature) ______________________

Date ______________

Relationship to Patient ___________________________________