BRYAN WALL DDS

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Consent for Services and Financial Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

_____Initial Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company. Insurance companies reserve the right to downgrade services or apply an alternate benefit that is least costly to the insurance company; despite the doctor's diagnoses of what is in the patient's best interest for their dental care. All treatment plans are an ESTIMATE ONLY based on the information provided to us from your insurance. All claims are subject to review, any missing tooth clause and/or waiting periods by the insurance company. Your dental benefits quoted are based on benefits used at this office only. If you have used your dental benefits at any other office, we may NOT have updated information. Any portion of the cost of dental treatment that insurance does not cover or denies coverage for is the patient's responsibility.
If unpaid accounts for dental services exceeds 90 (ninety days), this office will notify the patient with one final mailed statement. If payment is not made by the due date, the account will be turned over to a collection agency that will report delinquent payments to the credit agencies.

I understand that a treatment plan fee estimate listed for dental care can only be extended for a period of ninety days from the date of the patient examination and diagnosis for said treatment.

I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize the request for my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

I grant my permission to you or your assignee, to telephone me at home, my work or my cell phone to discuss matters related to this form.

Our office sets aside a designated time, our facility and individual attention for each scheduled patient appointment. It is our office policy that we require a minimum of **24 business hour prior notice** if you cannot make your scheduled appointment time to avoid a $35 cancellation fee per hour scheduled. Cancellations must be received during business hours; cancellations after hours or on weekends that are less than 24 business hours will be charged the cancellation fee.

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

_____Date_____Relationship to patient_____
Signature of patient, parent or guardian