PATIENT'S NAME:_____

Financial Agreement. In order to control the cost of billing, we request that charges for office visits be paid at the time of service, unless prior arrangements have been made with our Business Manager. There is a $25 charge for all checks returned by your bank. Please indicate your choice of payment below:

A._____ Payment in full as treatment begins (Cash/check 5% discount, Credit Card 3% discount)
B._____ Insurance, you are responsible for any balance not covered. (After 60 days the full office fees become your responsibility).
C._____ Financial arrangements upon approval through Care Credit

Authorization, Assignment, and Guarantee of Payment. I hereby consent to any medical or surgical treatment rendered to me and guarantee payment of charges incurred on my behalf. I hereby assign and authorize payment of insurance benefits directly to Center Square Family Dental (hereinafter "CSFD"). I will be financially responsible for all services. In the event payment is not made at the time and in the manner required, the undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing forty percent (40%) of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the costs associated with processing the collection action.

Financial Information. I authorize the release of financially-identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to any collection agency or collection attorney selected by CSFD to collect on the account should such action become necessary.

Finance Charge. I hereby agree to pay a finance charge of 1.5% per month (18% per annum) on any unpaid balance on my account.

Treatment Authorization. I authorize CSFD, its owners, employees, and associates, to perform any procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. This includes the administration of any sedative (including nitrous oxide), analgesic therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

Anesthesia Acknowledgment. I understand that the administration of local anesthetic may cause an untoward reaction or have side effects which may include, but are not limited to: bruising, hematoma, cardiac simulation, temporary or permanent numbness, and muscle soreness.

Assumption of Risk. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and/or operative treatment procedures undertaken to obtain potential desired results for me, my minor child, or ward. I understand and accept that these results may not be achieved, in whole or in part. I agree that my consent to any treatment includes an acknowledgment that I will have had any and all procedures explained to me and I will have been given the opportunity to ask questions beforehand, else I would not have given my consent.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to the terms stated above and accept this document as legally binding.

Signature_____Date_____
(Patient, Legal guardian or authorized agent of patient)
Witness_____Date_____

HIPPA Privacy Policy

We are required by law to maintain the privacy of your health information. You have the right to obtain a copy of our Notice of Privacy Policies directly from our office at any time. By signing below you acknowledge you have reviewed and understand these policies.

_____ _____

Printed name Signature of patient/Legal guardian/Authorized agent

Insurance Policy

Due to increasing problems with insurance companies, we are asking for your help and understanding. We cannot control nor take any responsibility for the decisions and/or actions of your insurance company. The policy is between you and your insurance provider. We will be happy to help file your claims and assist with any problems, but ultimately, it is your responsibility. Unfortunately, our experience is that insurance companies are constantly changing their policies, benefits, and coverage. We are no longer able to predict what they will pay for or what will be denied. It has become so unpredictable that what was once a simple process to fill out a claim form and submit for payment is now a complex task. *Please initial all to continue:*

_____(Please initial) I understand that if I have dental insurance, I will pay my estimated portion at the time of service and CSFD will help by billing my insurance for me. If I have primary and secondary insurance, I understand that there is always a co-payment of some kind. CSFD will assist me in submitting the claims to both insurance companies, If, after 60(sixty) days, my insurance still has not paid, I will be notified and will pay the remaining balance at that time. Any payments made by the insurance company after that time will be refunded to me.

_____(Please initial) Our treatment estimate given at the time you are seen in our office is based on the information given to us by your insurance company. It is not a guarantee of payment. It is your responsibility to know your insurance plan and the yearly maximum benefits and coverage. We are happy to help and will do all that we can to assist you with your insurance.

_____(Please initial) I understand that insurance is a contract between me, the patient, and the dental insurance company. I further understand that if my insurance does not cover a specific procedure, treatment, or diagnosis, it is my responsibility to resolve such with my insurance company and not the responsibility of CSFD.

_____ _____

Printed name Signature of patient/Legal guardian/Authorized agent

Appointments

_____(Please initial) I understand and agree that I will be charged $35 for each missed or cancelled appointment not cancelled 24 hours in advance.

Phone and Text

My mobile phone number is _____

_____(Please initial) I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.