Hamburg Family & Cosmetic Dental Group, LLC

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Office Procedures & Policies
Consent for Treatment
Authorization for Insurance Submission

Here at Hamburg Family & Cosmetic Dental Group, LLC, we are proud to offer high quality dental care with individualized attention. To best serve our patients, we have designed the following procedures and policies. Each section also requires your initials. Please feel free to ask us any questions. Thank you.

Insurance, Payment, and Financing

I. Insurance

If you have insurance, we are anxious to help you receive maximum benefits. Insurance is not a simple matter these days. As a courtesy to you, we will explore and explain your benefits, and we will also submit your insurance claims for you. **Please note that unpaid balances from your insurance company become your responsibility.** *Initials* _____

II. Payment

Unless **previous** arrangements have been made, payment is expected at time of service. When multiple visits are required for treatment, your payment may be split over the number of visits required. If you have insurance, we will estimate the portion you are responsible for. However, if your company does not pay in full, you are responsible for the difference. We accept cash, checks Visa, MasterCard, Discover, or AMEX.

If final payment cannot be made when services are completed, the balance MUST be placed on a credit card. If you do not have a credit card, a separate Financial Agreement Form will be filled out and signed by you. A copy of your driver's license, plus other documentation, will also be required.

If extensive treatment is necessary, you will most likely have a consultation appointment, which will include financing options. Please see the next section for details. *Initials* _____

III. Financing

We offer multiple financing options for extensive treatment. These options include "Pay As You Go," "Payment By Phase," "Healthcare Financing Options," and "Automatic Credit Card Payment" options. Our "Financing Options" form lists details. Please ask us for one if you are curious and will be inquiring about financing. *Initials* _____

Miscellaneous

A. Bounced checks are subject to a $30 fee.

B. Outstanding Balances:

Anyone leaving the office with an outstanding balance, especially when previously agreed-upon arrangements have been broken, will be required to sign a Financial Agreement.

C. Interest Charges and Failure to Pay Accounts:

Any outstanding balances not paid within 30 days of receiving a statement will be subject to interest at 18% APR or a $3.00 service charge, whichever is greater. Failure to make full payment within 90 days will result in the actions of a collection agency or court, with an additional collection fee of $150.00, plus reasonable attorney fees.

D. Cancellation Policy

For most appointments, we require 24 hour notice if you are unable to keep your appointment. **Some appointments require 48 or 72 hour notice, and you will be informed of these**, **as necessary**. Failure to give us this notice will result in a $15 charge per quarter hour scheduled. We are well aware

that emergencies arise, and we are not insensitive to this issue. However, if you do not call us to let us know what is occurring, we reserve the right to impose this fee. We cannot provide our patients with the level of excellence expected of us if we do not have your cooperation with respect to keeping your appointments.

E. Confirmation Policy

We will call you the day before to remind you of your appointment. If your appointment is more than one week away, you will receive two calls: one a week before, and a second call the day before. Saturday appointments will be confirmed on Thursdays. **Please note that these calls are courtesy calls: your appointment is still your responsibility.**

Initials _____

I have read all the above sections, and all my questions have been answered to my satisfaction.

Name (print) _____

Signature _____ Date _____

I hereby give consent for the following minors: (FIRST AND LAST NAMES!!):

Name of Minor (First & Last Name)	My relationship to minor	Name of Minor (First & Last Name)	My relationship to minor
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL CONSENT FOR TREATMENT

I understand that all dental and anesthetic procedures have associated risks. These may be but are not limited to:

1) Drug reactions & side effects 2) Damage to adjacent teeth or fillings

3) Post-operative infection 4) Post-operative bleeding that might require additional treatment

5) Bruising, swelling, sensitivity, or pain

6) Failure of the dental procedure necessitating additional treatment

7) Complications during treatment necessitating referral to a specialist.

I understand I have the right to ask questions about my treatment, including alternatives and risks, as well as the consequences of doing nothing. I further understand that no guarantees have been made or offered.

Patient (or guardian) Signature _____ Date _____

PAYMENT ASSIGNMENT AND RELEASE

I understand that I am fully responsible for this account, and for all minors listed above. In the event that insurance is involved, I authorize all insurance benefits be payable to this dental practice. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from the insurance company. I authorize the use of this signature on all insurance submissions.

_____	_____	_____	_____
Print Name of Responsible Person	Sign Name of Responsible Person	Relationship to Patient	Date