Financial Options

I choose the following method of payment for my dental care and the care of my dependents:

1. I have no Dental Insurance:
( ) I elect to pay with ( ) cash/check or ( ) credit card on all visits as treatment is completed.
( ) I wish to apply for your in-office finance plan (Care Credit). I understand on approved credit, I may finance up to $10,000 and make monthly payments over an extended length of time or choose an interest free option as offered by Care Credit.
( ) I prefer to secure a bank or credit union loan for the entire amount.
( ) On treatment amounts over $500, I elect to pay half on the preparation date and the balance on the completion date for multiple appointment treatment plans.

2. I have dental insurance through (company name)_____. Please present your insurance card to the front desk so a copy can be made.
( ) I elect to pay my deductible and any uninsured portions as treatment is completed.
( ) On treatment amounts over $500, I elect to pay 50% of my uninsured portion on the preparation date and the balance on the completion date.
( ) On treatment amounts over $500, I elect to pay the uninsured portion on the office finance plan (Care Credit). I understand on approved credit I may finance up to $10,000 and make monthly payments over an extended length of time or choose an interest free option as offered by Care Credit.

I understand the dental specialists at Dental Health Partners will provide dental services to my self and my dependents using the benefits of my insurance coverage to the full extent; however, insurance benefits do not determine the treatment needed, recommended or completed. The dental expertise of the doctors will determine the best treatment for each patient's dental health regardless of insurance coverage. As a courtesy, an insurance estimate will be supplied with the insurance information available. These estimates are only estimates and do not guarantee payment to be received by insurance. Any amount not paid by the insurance will be the responsibility of the patient or patient's responsible party.

Consent for Services

I request and consent to an exam and radiographs as deemed necessary for diagnosis. I also request and consent to needed treatment as it is explained to me. If any unforeseen condition should arise in the course of treatment, I further consent to any procedure deemed necessary for my well-being. 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.
I hereby authorize the treating dentists of Dental Health Partners to release to the insurance company any information including the diagnosis and records of any treatment rendered to me during the period of such dental care. I also authorize and request the insurance company to pay directly to the above clinic the amount due for dental treatment. I also authorize the release of my dental records to referring dental providers or other only as deemed necessary by the dentists at Dental Health Partners.

I have read the above conditions of treatment and agree to their content:

_____Date_____
Signature of Patient, Parent, or Guardian