# Garrisonville Dental

## Consent to Dental Treatment

I, (print name) _____, hereby give **Garrisonville Dental** my consent to perform dental treatment considered necessary.

I understand that as the treatment proceeds there may be need to change the treatment plan. If this occurs, I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible. I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

When treatment plans are presented, the expected insurance payment is an estimate. If for any reason the Insurance Company does not pay the amount estimated, I will be responsible for the difference.

In order for us to collect any amounts you may owe us, you authorize us and our affiliates which include debt collectors, to contact you at any telephone number associated with your account. Methods of contact may include the use of automatic telephone dialing systems and automated SMS text message reminders.

As a courtesy, we will file a claim for you. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. If insurance has not paid claim within 90 days, patient is responsible to pay for services rendered and then reimbursed when insurance payment is received.

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. If an extended payment plan is desired, please ask us about the CareCredit program.

We reserve a specific block of time for each of our patients. An appointment with you is a bond of trust that we will be here to serve you. We expect you to be present for each of your appointments. It is extremely difficult to provide you with the kind of treatment that you expect from us with constant short notice changes on our schedule. As a result, we charge $50 an hour for all cancellations made less than 24 hours in advance.

x_____

Patient Signature If a minor, Signature of Parent or Guardian

Date _____