

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

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.

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 an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care will be honored for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

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

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Pousson Family Dentistry

*Financial Arrangements
Broken Appointment Information
Truth in Lending Statement*

It is the policy of this office to collect payment for services as they are rendered. Patients with insurance benefits are expected to pay their estimated portion and deductible at the time of service. A minority of insurance plans send benefits directly to the patient. In that event, the patient will pay in full and be reimbursed by their insurance carrier. **This office is a participating provider for Delta Dental Premier insurance plans only.** Dental insurance benefits are an agreement between you and your insurance company. As a courtesy for our patients, we prepare and file the insurance claims.

Payment Options

- ❖ We accept cash, checks, and Visa, MasterCard, and Discover credit or debit cards.
- ❖ For payment plan options ask us about Care Credit.

All financial questions or special arrangements **MUST** be made at least 24 to 48 hours before your appointment.

Broken Appointment Information

The time for your dental appointment has been reserved exclusively for you. We request 24 hours notice to reschedule an appointment. If your appointment is longer than two hours, please allow 48 hours notice.

- ❖ A minimum fee of \$50.00 may be charged for missing an appointment or for changing an appointment without adequate notice

I have read and understand all policies mentioned herein and recognize that I am ultimately responsible for all incurred fees.

Signature _____

Date _____

Pousson Family Dentistry

Insurance Information

- ❖ Dental benefits are not meant to determine your dental care but are to assist you in the payment of your treatment.
- ❖ We are not responsible for determining what your particular benefits are. Most policies cover what they consider a *"usual and customary fee."* However, the insurance company establishes these fees to meet their needs, and they are not always the same as the fees that may be charged by our office.
- ❖ We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours, and financial arrangements must be defined before dental treatment begins.
- ❖ You are responsible for portions not covered by your policy on the day of service.
- ❖ Your insurance policy is a contract between you and your insurance company. Any problems of non-payment or a delay of payment are your responsibility.
- ❖ Any insurance balance over 60 days old is delinquent and is your responsibility to pay.

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process this claim for myself or family members.

Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS

I authorize payment of dental benefits to the named provider for professional services rendered to me or my family members.

Signature _____ **Date** _____