

CONSENT FOR SERVICES AND FINANCIAL POLICY

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 cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL

Thank you for choosing Isolani Endodontics as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. All patients must complete our information and insurance form before seeing Dr. Isolani.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, & CARE CREDIT

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ESTIMATED portion on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any changes in treatment.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have any changes in your insurance coverage prior to your appointment. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. I understand I will need to keep a credit card number on file for any outstanding balances to my account.

MISSED APPOINTMENTS

We respectfully ask that you give us a minimum of 24 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping your scheduled appointment(s).

NSF CHECK POLICY

Payments made by check that are not honored by the bank will incur a returned check fee of \$25.00. The payment will be reversed from the appropriate account when a check is returned by the bank which could result in additional fees being added to the account. You will have 10 days to reimburse payment in the form of cash, cashier's check, certified funds or money order.

AUTHORIZATION & RELEASE:

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers. I authorize and request my insurance company to pay directly to Dr. Isolani . I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

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

Signature of patient, parent, or guardian

Date