AG
ANTHONY GULDE, D.D.S.
Smiles for a lifetime

FINANCIAL POLICIES & MEDIA CONSENT AGREEMENT

To control overhead costs and unfortunate misunderstandings, our office requires all patients to make financial arrangements with us before we provide comprehensive treatment. In order to receive treatment from us, you are making the following representations to us, which you affirm that you have read, understand, and agree to:

1. For your convenience, we have many different payment options including Cash, Check, Discover, MasterCard, Visa, Springstone Financing and Care Credit. I understand that full payment is due at the initiation of service under a treatment plan that I or any of my dependents have requested. We do not bill patients for services rendered.

2. I understand that if I opt to discontinue treatment for a procedure I requested this dental office to perform, including but not limited to partials, dentures, crowns, bridgework, or surgical preparatory work. I will be responsible for paying all lab related costs for materials and services that were provided for my benefit prior to my decision to discontinue such treatment and that all such costs will be deducted from any refund that I may be entitled to.

2. I understand that I have the right to dispute charges on my account and agree in good faith to resolve such disputed charges with this dental office. To the extent that I am unable to resolve such matters directly with the patient liaison, I agree to pursue resolution through an informal mediation process with an office representative rather than through civil litigation.
3.
4. I understand that unless patient records are sent electronically and directly to another provider, the charge for copies of x-rays and treatment information is currently $25.00.

5. Due to the extensive nature and time consumed in setting up properly for an appointment, we may require a fifty percent deposit for scheduled treatment. If an appointment is not cancelled with a 48-hour notice, a fee may be incurred of $35 *or* 25% of the total cost of treatment, whichever is greater. If we are unable to confirm an appointment, we will still be setup and prepared if the deposit has been made.

6. I understand that any and all account balances over 30 days old will incur a monthly interest charge at the maximum legal rate allowed. There is a billing charge of $1.00 per statement.

7. To allow us to properly diagnose and see areas that are difficult to see during the examination process, we take intraoral and extraoral photos of your teeth and surrounding facial structure before, during and after treatment. By signing this form, I also hereby give the absolute right and permission to use any of those audio/video materials, including photographs/slides/video solely for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection the use of said materials.

THE FOLLOWING ARE FOR INSURED PATIENTS ONLY.
If you don't have insurance on file, then the next three statements don't apply to you.

8. As a courtesy, with some insurance, this office will estimate the insurance coverage from the information you and your insurance company provide. This estimation may differ from the payments that are ultimately made by my insurance carrier and I am aware that *I am responsible for any amounts not paid by my insurance for any reason.* This office only estimates insurance assistance for a select number of insurance companies. After the New Patient Exam, we require a credit card authorization form be completed to use this convenient service. This is a guarantee of payment by you if your insurance fails to provide the financial assistance. Your card will be charged the balance after insurance has sent the Explanation of Benefits. If you choose not to have an authorization form on file, we will estimate the insurance coverage to be zero and will still be glad to provide you a claim form.

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9. I realize that it is solely my responsibility and not the responsibility of this dental office to confirm which treatments or procedures are covered by my insurance.

10. I understand that all insurance claims from treatment that I receive are being filed with my authorization as a courtesy to me and are subject to review by my insurance carrier. I understand that the office will submit a claim with my insurance carrier up to 2 times per appointment and that any further insurance appeal is solely my responsibility. I also acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance within 30 days of the procedure being performed even if I am appealing the denial of insurance benefits by my carrier.

I have thoroughly read, understand, and agree to the above terms and conditions. Signature below is acknowledgement that I have received this Notice of Financial & Media Consent Agreement with this dental office:

______________________________	______________________________
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN	**DATE**

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