FINANCIAL POLICY CONSENT FORM

We welcome you and your family to Bliss Family Dental. We look forward to providing you with quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you review and complete or office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your dental treatment.

Dental Insurance benefits: You need to be aware that:

We will always do our best to help you to maximize your benefits. Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

Dental Insurance Claim Payments:

As a courtesy to all of our insured patients, we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.

Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

I _____understand and accept the financial and insurance policies listed above and have had any and all questions answered to my satisfaction.

I_____ agree to pay for all treatment in a timely fashion as described.

Fill Out Front & Back

I _____ hereby authorize my insurance benefits to be paid directly to Bliss Family Dental. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services the day of service. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance. I agree to pay such charges in full.

I _____ hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is available by request.

PAYMENT OPTIONS AVAILABLE

:Cash/ Personal Check

:Most Major Credit and Debit Cards

:CareCredit -OAC

Patient/Legal Guardian	Date	Witness	Date

Fill Out Front & Back