ANDERSON DENTAL

PAYMENT POLICIES, RESPONSIBILITIES & SIGNATURE ON FILE

Thank you for choosing Anderson Dental. Our mission is to deliver the finest, most cost effective dental treatment available. Following your exam, the doctor will advise you of a plan for treatment. Additionally, we will discuss today's fees and any further treatment plan including fees as they are today. We require payment prior to the beginning of treatment.

*****PLEASE INITIAL WHERE NOTED WITH LINE:**

____ **Insurance is filed as a courtesy for the patient. Insurance co-payments are due at the time of service. Final responsibility for payments rests with the patient. The patient understands that it is their responsibility to report any changes in insurance coverage.**

____ PAYMENT OPTIONS THAT WE OFFER:
Cash/Check - Visa/MasterCard/Discover - Care Credit Financing (ask for application) - Pre-payment Option

____ A charge of $30 will be applied to accounts for any returned checks.

____ BROKEN APPOINTMENT POLICY:

I understand that a valuable amount of time is saved for all my appointments and if I fail to give proper notice of 24-48 hours prior to any appointment I will be paying a $50 broken appointment charge. If a second appointment is made and completed within reasonable time the charge will be reimbursed toward the treatment. Anderson Dental reserves the right to dismiss a patient from our practice for numerous appointments broken without 24-48 hour notice or appointments not confirmed.

____ APPOINTMENT VALUE

When scheduling treatment to be completed I understand that I will be paying a pre-treatment deposit with values as follow… (If treatment is not completed pre-treatment deposit will be forfeited.)
Under $500 of treatment a $50 deposit - Over $500 of treatment a $100 deposit - Over $1000 of treatment a $200 deposit
Any treatment over $2500 will be paid in full at least 2 days prior to treatment.

____ CONSENT FOR TREATMENT

I hereby authorize Anderson Dental and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize Anderson Dental and designated staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required providing proper care. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

____ The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information. I also have read and understand the broken appointment policy and my responsibilities. I have had all of my questions answered regarding these issues and agree to abide by these policies.

_____	_____
Patient Name (PRINTED)	Date

_____	_____	_____
Patient Signature	Parent/Responsible Party Signature	Relationship to Patient