New Baltimore Family Dentistry

Office & Financial Policy

PATIENT INFORMATION			
First Name		Last Name	
Birth Date		Email	

TO THE PATIENT (OR ADULT GUARDIAN)

Please read the following statements carefully

INSURANCE

Your insurance plan is a benefit provided by your employer to you and an agreement between your employer and the insurance company on your behalf. We will file your claims as a courtesy to you and accept the assignment of benefits allowing payment to us IF that benefit is available under your particular plan.

Our fee schedule is the same for all our patients. What your insurance pays is a benefit to you and does not affect your responsibility to pay any deductible, co-insurance, or any other balances not paid by your insurance company. As with all our patients, we will discuss the fees for treatment prior to rendering the service. We can assist you in determining your possible benefit for your dental treatment as provided under your plan.

PAYMENT

We accept payment by cash, check, Visa, MasterCard, American Express, Discover, and CareCredit.

I understand my account will be noted with a failed appointment. Once you have 3 failed appointments, you may be discharged from the office as a patient.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and cost of collection.

CONSENT

Your initial visit will entail a comprehensive examination and any necessary radiographs to diagnose dental disease or a limited examination and treatment to relieve pain or discomfort. Payment for this first visit is expected at the time of service.

We invite you to discuss any questions regarding our services and fees.

I authorize any necessary radiographs and supportive documentation necessary to allow the doctors of New Baltimore Family Dentistry to diagnose my dental needs. I am aware that a consultation / treatment-planning appointment will be scheduled so that I can make an informed decision on additional treatment.

FORM COMPLETION

I have read and understand the above information. By my signature below, I consent to the treatment described above and acknowledge my financial responsibility for all fees incurred regardless of my insurance reimbursement.

Signature of Patient, Parent, Legal Guardian		Date	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	

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