Stephen M. Cambre, D.D.S.

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Office Financial Policy – Informed Consent

Thank you for selecting our office to care for your dental needs. We are committed to your treatment being successful. Please understand that payment of any fees incurred is considered part of your treatment. We feel it is important for you to have a clear understanding of your financial commitment to our office.

Please note that payment by cash or check is expected at the time services are rendered. We except Visa, MasterCard, Discover and American Express are also welcomed. Arrangements can be made to make necessary treatment affordable; however these must be discussed prior to the beginning of treatment.

NEW POLICY CHANGE EFFECTIVE 04/10/2019: **Above mentioned payment will be expected at the time of arrival for appointment. There is a $50.00 Fee for a NO SHOW appointment. _____ Your initial.**

Regarding Insurance: I**f you have dental insurance, it should be understood that this is an agreement between you and your insurance company. Dental treatment and resulting fees are an agreement between you and your doctor. You are entirely responsible for the payment of your entire bill regardless of the status of your insurance claim.** If you have insurance coverage we will estimate your patient portion and the expected insurance portion. **We have found that most insurance companies cover up to 100% of preventative, 80% for basic, and 50% for major services. "Due to the reasonable and customary fee schedule set up by your insurance company, they may not pay the full 100%, 80%, or 50% of our fees.** We will expect the estimated patient portion to be paid at the time of the visit. As a service to you, we will electronically file an insurance claim and wait for the estimated insurance payment. If for any reason the insurance company does not pay their expected portion, we will bill you for the non-covered amount.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and our fees reflect our level of care and skill. They are well within the usual and customary charges for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Unusual Circumstances: Should a situation arise that makes it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our office staff. This will avoid misunderstandings and enable you to keep your account in good standing. Except when hardship warrants otherwise or other arrangements have been made, accounts over 90 days past due are referred to a collection agent.

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not receive by the agreed upon dates, I understand that this may result in collection procedures.
4. I have received a copy of this office's Notice of Privacy Practices.

I have fully read and understand the above policies:

Patient Signature: _____ *Date:* _____

Doctor Signature: _____ *Date:* _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not due to _____ refusal to sign _____ Communication barriers _____Other Revised: 02/19/2019