Evergreen Dental Care

Authorization & Financial Policies

*Your signature at the bottom of this page indicates that you understand and agree to all of our policies

I voluntarily and knowingly request and consent to the services for myself (or my dependent), for treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of services, treatments, or procedures that have been recommended. I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for dental treatment. I also understand that the use of anesthetic agents embodies certain risks that can be explained to me upon request.

I understand that the office cannot know all the coverage limitations and rules regarding my insurance policy. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company, and me, my responsible party, and/or employer. The office is not a party to this contract. As a courtesy to me, the dental office will bill my insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the office. I acknowledge that it is my responsibility to provide the office with my current insurance information and any changes thereto. I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance benefits due to me for the services, treatment, and diagnostic methods provided and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services preformed and utilized by the dentists and others at the time that services are rendered. This includes services the occur after hours, or when the office is typically closed. Emergency appointments after hours will be charged and after hour fee that is due prior to any services being completed. Please be aware that not all services may be covered by insurance.

Initials_____

Although we will be happy to assist you should an emergency arise after business hours you are still responsible for all charges at the time. A charge of $200.00 - $500.00 will be applied to services after hours, in addition to regular treatment charges. We will gladly submit any and all claims that may or may not be covered by insurance after the patient has paid for these services. Once submitted, if insurance does cover any services that were provided during an emergency visit, the insurance will reimburse the patient directly.

All returned checks will be subject to a $25.00 returned check fee. Any account balance that remain unpaid for 90 days from the date of service shall accrue interest at the rate of 35% and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs accrued. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency or attorney to who, an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by email, phone number (whether a cell phone or landline) at any facsimile number, that I provide to the dental office or any agent at the dental office

Patient's Printed Name: _____ Date _____

Patient's Signature: _____

Guardian/Responsible Party, if minor: _____ Date _____

Printed Name of Guardian: _____