Consent for Services

We strive to see patients at their time. However, we are a medical facility and occasionally circumstances arise that require us to spend more time with a patient. We will always give you the same care and understanding.

Patients arriving 15 minutes late may be asked to reschedule as a courtesy to the following patients.

We reserve specific appointments for you. Therefore, short notice cancellations hinder us from providing care to others and delay you from obtaining the care that you need. If you find that you must reschedule, please give us as much notice as possible. We require at least 24 business hour notice for any rescheduled or cancelled appointment. Any Appointment that is rescheduled, cancelled or broken with less 24 business hour notice will result in a *$25.00 charge*.

Our mission is to provide you with optimal dental care regardless of insurance coverage. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. The fee for a returned check is $30.00 A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that should this account be turned over to a collection agency for delinquency, a collection and/or attorney's fee of 35% and all related collection cost will be added to my outstanding balance and payable to the collection agency by me. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

_____Date: _____Relationship to Patient: _____

Signature of patient, parent or guardian

_____Date:_____ Relationship to Patient:_____

Signature of guarantor or payment/responsible party

Please see other side ----------→

FINANCIAL POLICY OF DOCTOR FREDERICK DENIKE

Payment is due when services are rendered. Payment may be made by cash, check, debit card, or credit card (Visa, Master Card, American Express, and Discover, Care Credit). Payment for procedures not specifically covered or fully covered by an insurance carrier are due at the completion of each visit this includes deductibles and co-payments.

METHODS OF PAYMENT

PAYMENT IN FULL:

Cash, check, debit card, health savings card or credit card is accepted for full payment the day of or prior to treatment. The insurance payment sent by your insurance company will go directly to the patient (guarantor).

ESTIMATE-PLUS PAYMENT PLAN:

Payment of the estimated Patient Portion, to cover any insurance shortfall in coverage, is to be paid at the time of treatment. The practice will then accept the insurance's payment and then bill any remaining balance if necessary, or refund any overpayment to the patient.

I have read this document and understand that this is an explanation of Dr. Frederick W. DeNike financial and insurance policies and I agree to comply.

I assign my insurance benefits to the provider listed above. I understand this form is valid for one year unless I cancel the authorization through a written notice.

SIGNATURE_____ DATE_____

X-RAYS (REQUIRED)

I understand it will be my responsibility to pay for any and all x-rays that my insurance company does not cover for whatever reason.

SIGNATURE_____ DATE_____