

***Insurance, Fees and Payment Plans***

Excellent dental care is a wonderful investment for your comfort, appearance, self-confidence and health. We are sensitive to your needs and financial concerns. If you have any questions or we can help in any way, please feel free to contact us.

**Estimate in Writing – Fast & Easy:** We will always provide you with a written estimate of cost before we start any treatment. To make payment as fast and easy as possible, we accept Visa, MasterCard, Discover, American Express and debit cards. We also accept checks and cash payment.

**Appointments:** Once you have reserved time, please do not change your appointment. For visits of 90 minutes or more, we ask for 20% down payment to reserve the doctor’s time. We encourage longer appointments when possible to get as much done for you in the fewest visits possible.

**Appointment Cancellation: We do require a 48 hour notice to cancel or reschedule your appointment, in order to avoid a cancellation fee. There will be a $50 charge for every hour that we have set aside for your appointment.**

**Insurance – Express VIP Checkout:** Your insurance coverage is an agreement between your carrier and you, and not us. We are happy to help with the processing of your claims, but have “no control” over how much or little they intend to cover for a particular treatment. To accept insurance, we request your estimated co-payment upon arrival so you don’t have to wait after your appointment. We also ask that you leave a credit card on file for any additional fees that may come due. When your insurance is received, we automatically credit or debit your charge card to make your payment correct. No more dental bills to worry about!

**Estimating Your Benefits:** Our staff are experts on insurance. They try to estimate your benefits and answer any questions you may have. In most cases we experience very little difficulty in helping you procur payment. Occasionally, a carrier will be “difficult.” If insurance payment is not received after 60 days, we automatically bill your credit card for outstanding balance.

**Please do not ask us to change codes to obtain better benefits for you**. This is a felony insurance fraud. By law, we are also not allowed to waive deductible, co-payments or non-covered services for you. If you do not provide complete or correct information, or if eligibility cannot be verified, we cannot process your claim and must ask for payment-in-full.

**Payment Plans – Making Care Affordable:** We offer several payment plans to make the best care fit almost any family budget. For greatest flexibility and the most payment options, we use some wonderful outside services. Some plans are interest-free. Please ask if you would like more information.

**Billing Problems:** Accounts over 30 days incur 18% annual interest charge. Balances over 90 days are generally referred to a third party for collection. You are responsible for collections costs. The fee for insufficient funds is $35.

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**General Dentistry Informed Consent**

I hereby authorize and direct Dr. Hurt and/or dental auxiliaries of his choice, to perform the following treatments, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids, such as Exams, Cleanings, Root Canals & the following below.

**Drugs and Medications:** I understand antibiotics, analgesics, and other medications can cause reactions including but not limited to redness, swelling, pain itching, vomiting, and/or anaphylactic shock.

**Changes in Treatment:** I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgment of the dentist.

**Removal of Teeth:** Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery etc.) and authorize the dentist to remove teeth if necessary to have further treatment. I understand the risk involved in having teeth removed of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist, if complications arise during or following treatment, the cost of which is my responsibility.

**Crown, Bridges, Inlays/Onlays and Veneers:** I understand that sometimes it isn’t possible to match the color of natural teeth with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure they are kept in until my permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridges, inlays/ onlays or veneers (including shape, size, fit and color) will be before permanent cementation. It is also my responsibility to return for permanent cementation.

**Fillings:** (For Insured Patients) I understand that my insurance may not cover tooth colored fillings for my posterior teeth. Dr. Hurt and his associates do not believe in placing restoration containing substances know to cause toxic effects to our patients, in this case mercury; they will not perform these types of services unless there are no viable alternatives. I understand I am responsible for paying the difference between what my insurances pays for silver fillings and Dr. Hurt’s UCR fee for tooth color fillings.

I understand that there is risk involved in treatment and hereby acknowledge that these risks will be explained to me, that I will have the opportunity to ask questions regarding the treatment and risks. I acknowledge no guarantee or assurance has been made by anyone regarding my dental treatment, which I have authorized. I understand regardless of any dental coverage I may have, I am responsible for payment of dental fees. Should any dispute arise over dental services provided for me, that is, any dental services allegedly unnecessary, unauthorized or improperly, negligently, or incompetently performed, said dispute will be submitted to a Peer Review by local component of The American Dental Association or comparable committee. The decision of the Peer Review shall be binding in all parties, I have read, understand, and agree to the above

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_