

**SIGNATURE ON FILE**

1. HEALTH UPDATE – I understand it is my responsibility to inform my dental healthcare provider of any and all health/medical or medication changes since my last visit. (Your signature at the bottom of the page will acknowledge your update.)
2. MINOR CHILD TREATMENT RELEASE – I give permission to Dr. Thomas Albiero, Dr. Keith Templin, Dr. Cynthia Jakusz, Dr. Chad Zambon, Dr. Kyle Menne and/or their designated assistant or hygienist to perform any and all dental techniques and procedures including the administration of dental anesthetics on my minor child(ren), whether or not I am present at the actual appointment when the treatment is rendered. (Your signature at the bottom of the page is permission for release of treatment.)
3. HIPAA – The Health Insurance Portability and Accountability Act (HIPAA) are now in effect as required by the Federal Government. A copy of our Privacy Policy is available for you to read if you choose to. We will also provide you with your own copy if you would like one. (Your signature at the bottom of the page will acknowledge the receipt of notice of privacy practices.)
4. INFORMATION RELEASE – I authorize the release of any information necessary to hospitals, doctors offices, dental offices, and/or to file claims for insurance benefits or a means of recovering fees. (Your signature at the bottom of the page will allow us to share without a signature on each individual form.)
5. INSURANCE AUTHORIZATION – I assign directly to Dr. Thomas Albiero, Dr. Keith Templin, Dr. Cynthia Jakusz, Dr. Chad Zambon and Dr. Kyle Menne dental insurance benefits paid for services rendered. I understand that I am financially responsible for all fees incurred. (Your signature at the bottom of the page allows assignment.)
6. FINANCIAL POLICY – The best dental care can only be maintained through complete understanding of both the dental care required, and the financial arrangements for that care. Our dental office personnel have been trained to assist you with any question that may arise in these areas:

METHOD OF PAYMENTS: Payment will be discussed at each visit.

The options we offer are:

1. Payment at time of service. We offer a 5% discount on cash payment or 3% on credit card payment. Account balance must be cleared at time of visit to qualify.
2. We accept MasterCard, Visa, Discover or American Express.
3. We also offer several commercial financial options so that you may have the dental treatment you need.

DENTAL INSURANCE: Insurance may cover cost of some of your charges. As a service to you, we will submit claims to your insurance company for you but you are ultimately responsible for the entire bill. Since insurance may not cover the entire cost of your service, you are asked to make regular monthly payments to clear any balance within 90 days. Our staff will be happy to assist you in calculating this estimated amount. Should there be an overpayment in the final analysis; the refund will be made directly to you. It is necessary that you provide us with accurate insurance information. You may also be asked in some cases to check with your insurance company on coverage or payment irregularity.

ACCOUNTS: We do not become involved in domestic matters. The parent accompanying any minor will ultimately be held responsible for the account. We will send one bill for services and do not divide account balances. We will help track personal payments to the best of our ability and send reports upon request.

LATE PAYMENT CHARGES: A service charge of 1.5% per month will be added to all accounts 90 days or older. Should you have any questions about your statement, please call the office, we will make every effort to answer and resolve any problems.

MISSED APPOINTMENT FEE: If there is a need to cancel or reschedule an appointment, this must be done at least 48 hours prior to the appointment time. Appointments missed or cancelled less than 48 hours in advance will be bill to you at a standard rate of \$50 per appointment. Insurance will not cover missed appointments. \*We reserve the right to charge up to \$100 per hour scheduled. (Your signature at the bottom of this page acknowledges your agreement to our financial policy.)

AGREEMENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PRINTED NAME \_\_\_\_\_