PRUDENTIAL DENTAL

RELEASE AND AUTHORIZATION FOR TREATMENT

1. I understand that there are no treatment guarantees.
2. I understand that my medical / dental situation can change, thus affecting the outcome.
3. I understand that all radiographs (x-rays), models, and any other diagnostic materials are the property of Prudential Dental Associates, Inc, and will be used by the Practice accordingly. This material may be used in a teaching environment.
4. As a patient I am entitled to a copy of my radiographs for a nominal fee upon written request.
5. I understand that there are health risks, although minimal, involved with any dental treatment.
6. I understand that even though I may have dental insurance, the ultimate responsibility for payment is mine. After a 30-day period, payment is due in full unless prior arrangements have been made.
7. If I miss a Hygiene appointment, or give less than a 2 business day notice for a cancellation or rescheduling, there will be a $75.00 fee assessed to my credit card on file.
8. I authorize my dental insurance company to pay Prudential Dental Associates, Inc. directly.
9. I understand that if I do not pay my bill in a timely manner, late fees and finance charges will accrue. If the services of a collection agency are required, that fee will also, be my responsibility.
10. In the case of a divorce, it is the patient who makes the appointment or accompanies the child that is responsible for payment for dental services rendered.

My signature below constitutes my agreement to the above statements and authorizes the Hygiene Cancelation fee to be assessed to my credit card on file.

Patient signature Parent / guardian for minor under age 18

VITAL INFORMATION ABOUT YOUR DENTAL INSURANCE

As a courtesy to our patients, our office will:

Complete your insurance claim form and submit them to your carrier for you with proper documentation included.

- Accept direct payment from insurance carriers
- Use current ADA coding for correct reporting of procedures.
- If necessary, re-file your claim for a second time within a 60 day period.

Your responsibilities as a patient:

- Pay fees not covered by your plan at time of treatment.
- Provide our office with the necessary information concerning your insurance coverage to allow correct filing of claims.
- Understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
- Pay any account balance not paid by insurance in 30 days.

HIPAA Privacy Statement, Assignment and Release

In the event that I, and or my dependents have dental insurance coverage, it is agreed that any or all dental insurance benefits are to be assigned directly to Prudential Dental. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Prudential Dental Associates may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I read the Notice of Privacy and acknowledge that I have been fully informed of all my rights.

Patient or Insured_____ Date_____

Guardian Signature_____