



## **PATIENT AGREEMENTS**

### **FINANCIAL AGREEMENT**

By signing below, you acknowledge and understand that payment in full for all services is required at time of visit, unless prior arrangements have been made.

### **INSURANCE FILING**

By signing below, you acknowledge and understand that you (patient) are ultimately responsible for payment in full on your account, not the insurance company. We do file dental insurance claims as a courtesy to our patients. You understand that we can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event your insurance company does not pay as much as expected, you understand that the remaining balance is due and payable immediately by you.

### **ASSIGNMENT OF INSURANCE BENEFITS**

By signing below you hereby assign all insurance benefits directly to our office, which are otherwise payable to you. You also hereby authorize the release of any information relating to any claims. You understand that you are financially responsible for charges not paid by the assignment.

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**Responsible Party Signature**

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**Date**

### **DELINQUENT ACCOUNTS**

By signing below you acknowledge and understand that all delinquent accounts (90 days or older) are subject to reasonable service charges and/or legal interest rates.

**COLLECTION PROCEEDINGS**

By signing below you acknowledge and understand that in the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any and all reasonable collection costs and/or attorney fees, in addition to the balance owed. All accounts turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

**FAILED APPOINTMENTS**

Failed appointments are a significant contributor to rising healthcare costs. By signing below you acknowledge and understand that your account will be assessed a usual and customary fee of \$50 for any missed, changed, or no show appointments with less than a ~~48~~ hour notice.

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**Responsible Party Signature**

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**Date**

**CONSENT FOR SERVICES**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Ankita Bant or any other member of her staff responsible for any errors or omissions that I may have made in the completion of these medical history forms.

I give my consent for dental treatment that the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I have been advised of all probable complications of the dental treatment.

If patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume responsibilities connected with such treatment.

I understand that I am financially responsible for dental fees, with or without insurance payment.

I hereby authorize any insurance company to release all information with bearing on the benefits payable under this or any other plan providing benefits or services.

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**Responsible Party Signature**

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**Date**