Consent for Services

In the event that I was to swallow or aspirate a dental restoration such as a filling, crown, onlay, inlay, veneer, bridge, and implant etc... I will agree to have an x-ray taken at a healthcare facility of my choice to rule out any possible complications. Dental Specialty Associates has agreed to pay for this procedure. If I chose to decline the x-ray, I agree to sign a waiver and will not hold Imagine Dental liable for any and all future health related issues caused by the event.

If your doctor prescribes any medication for you, understand it that may cause drowsiness and you should not drive, operate heavy machinery, or sign important legal documents while taking that drug. Please consult your doctor if you have any questions.

Imagine Dental will not be held responsible for any valuables brought into the operating room suites. Please arrange for these items to be cared for by someone else while you are being treated.

Thank you for choosing Imagine Dental , this policy was designed to ensure that all finances (payments due) are recovered, which will allow us to continue to provide the best quality dental care for our patients. It is important to keep patient/office relationship strong, therefore it is important to assure payment for services is a smooth transaction by making it as simple and straight forward as possible.

Please read the following carefully, initial each statement and sign below. Thank you.

Initials

____ Payment is expected at the time services are provided. If patient has insurance, the estimated patient portion is due at the time of service. Any payment arrangement must be made in advanced.

____ DSA allows 45 days for insurance company to pay the insurance estimated portion. If insurance has not fully paid a claim after allowed time, patient is expected to pay the remaining portion.

____ As a courtesy to our valued patients, Imagine Dental verifies patient's benefits and generates claim charges to insurance company. Information received is NOT a guarantee of payment, benefits received are used to estimate patient financial portion.

____ Patient understands that any costs incurred during treatment are patient responsibility. Insurance may help pay for a portion of treatment. Treatment quoted is an ESTIMATE only. Patient will be responsible for any unpaid fees by insurance company.

____ A 1.8% interest may applied to the balance and additional costs of balance being sent to a collection agency (30% or greater) will be applied to the balance. Patient will be responsible for any legal fees.

____ Due to a high demand for appointment, missed appointments prevent us from scheduling appropriately and keep others in needs of urgent care from being seen. A $50.00 fee will be assed for all missed appointments not cancelled with 48 hour notice.

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

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

I hereby acknowledge that I have reviewed a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding the Notice.

Patient Printed Name: _____

Patient Signature: _____ Patient Date: _____