

Township Dental Associates P.L.L.C.
Consent Form and Financial Policy

Thank you for choosing our office for your dental care. We are committed to providing excellent care, great service, and a comfortable atmosphere and consider dental care a lifelong need. In order to serve you best, our dentist and/or hygienist will evaluate each tooth in your mouth, screen for oral cancer and review oral hygiene with you.

(Hereafter, "I", "You" or "Your" shall refer to you, the patient or parent. "We" or "Our" shall refer to Township Dental Associates PLLC)

As a condition of your treatment in our office, financial arrangements *must be made in advance*. The practice depends upon reimbursement from you, the patient, for the costs incurred in your dental care and treatment. *The patient's estimated portion is due at the time of the scheduled procedure*. It is your responsibility to provide us with your correct insurance information, including the insurance company name, address, telephone number, group name and number, and any other pertinent information. **We are unable to bill your insurance, or provide you with any estimate, if all of this information is not received at the time of service.**

I realize and agree insurance coverage is *estimated* and not a guarantee of the actual insurance payment; my actual coverage may be more or less than estimated. I realize and agree that my insurance will help pay part of my treatment and that any estimates quoted to me *are only estimates*. I am ultimately responsible for any portions remaining unpaid by the insurance carrier. I understand and agree that my insurance coverage is an agreement between the patient and insurance company, and Township Dental Associates does not have access to the specific coverage or exclusions of my plan. I understand and agree to pay any unpaid balance **within thirty days of date of invoice**. I understand and agree that I will be charged an interest rate of 1.5% per month for an unpaid balance on my account. I understand and agree that I will be responsible for any collection, attorney and/or court fees associated with my account.

(Please Initial Here) _____

I understand and agree that any fee estimate is valid for sixty days from the original date of the patient's examination. Thereafter, fees are subject to change without notice.

I understand and agree that ***I am required to allow at minimum a twenty-four hour notice*** to Dr. Genobaga, Dr. Mouzoon and/or staff should I need to reschedule or cancel my exclusively reserved appointment time. My dental appointment represents a shared responsibility for both dentist and patient. Office policy is to reschedule patients that are 15 or more minutes late for their appointment. In order to have quality dental care at affordable costs, these appointments must be kept. I understand and agree that if notice is not given, I WILL BE CHARGED a fee up to the amount of the scheduled procedure with a minimum fee of \$75.00. **(Please Initial Here)**

I give my consent to use local anesthetics, relaxants, analgesia (laughing gas), antibiotics or pain medication if deemed necessary for the completion of any dental treatment. Women taking birth control pills should be aware that antibiotics such as penicillin or erythromycin could possibly counteract the affects of the pill, and you could become pregnant.

I understand and agree that whenever a tooth is extracted, there is a *possibility* of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, *though rare*, that the paresthesia would be permanent.

I understand and agree that a root canal is *an attempt to retain a tooth that would otherwise require extraction*. Although root canal treatment has a high degree of success, **it cannot be guaranteed**. As the tooth is being treated, the root may fracture, instruments may separate, and portions of the canal may be inaccessible to instruments or sterility. It may require a referral for re-treatment, surgery, or (*rarely*) extraction.

I realize a specialist can perform any treatment proposed in this office. *I will inform the doctor if I desire a specialist to perform the proposed treatment.*

I understand and agree that the preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp is in a weakened condition, this may necessitate a root canal or extraction on that tooth in the future.

Insurance companies will usually pay at 100% for an adult prophylaxis. This may or may not be the type of cleaning appropriate for your needs. If you require a deeper cleaning or more extensive treatment, the doctor/hygienist will inform you when you are seen. In the event that you require more than an adult prophylaxis, your coverage may only allow for limited benefits. Please be advised that if you choose to proceed with treatment, you are responsible for all costs incurred, whether your insurance company pays or not. Please also be aware that the patient must continue routine bi-annual care (hygiene appointments with xrays) for our dental guarantee / warranty to be valid.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Minor Patients: The adult accompanying an minor and the parent/guardian of the minor are responsible for full payment. A PARENT OR ADULT IS REQUIRED TO REMAIN IN THE FACILITY AT ALL TIMES WHILE TREATMENT IS BEING RENDERED FOR THE MINOR.

I grant my permission to Township Dental Associates to contact me in writing or by telephone at home, work, or cellular phone to discuss any matters related to my account, appointments, or any other matter relating to my treatment and care.

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

Patient/Parent Signature: _____

Date: _____

Witness: _____

Date: _____