IOWA SEDATION DENTISTRY

IOWA SEDATION DENTISTRY PATIENT RESPONSIBILITIES

ASSIGNMENT AND RELEASE

I, the understated, have insurance and assign directly to Story City Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

_____

Date Signature

PATIENT AGREEMENT AND FINANCIAL POLICY

I hereby agree to be responsible for the costs of care provided by Iowa Sedation Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. I also understand that it is my responsibility to be aware of any limitations and benefits of my insurance policy. Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s). I agree to pay any outstanding balances owed within a timely manner of 30 days. Unpaid bills over 90 days will be sent to collections. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees. Any other arrangements would need to be approved by the Financial Coordinator and Dr. Binkowski.

I understand that patient portion(s) are to be paid in full the day of service. I also understand that if I have an unpaid bill it will need to be paid before I can schedule another appointment. **For sedation appointments, half of the patient portion is required to reserve an appointment. The other half of the patient portion is required to be paid at check in the day of appointment. Required notice for cancellation of ANY In-office sedation appointment is 3 business days. $100 NON-refundable fee will be retained in the event of a no-show or last minute cancellation.**

_____

Date Signature

MINOR/CHILD CONSENT

I, being the parent or legal guardian of _____ , do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I understand that payment for services is due at the time of service and the person bringing my child to their appointment will be responsible for payment unless I have left a credit card on file or have made other arrangements with the Financial Coordinator.

_____

Date Signature