21321 E Ocotillo Rd. #130 Queen Creek, AZ 85142 · 480.882.2300

Financial Policies & General Consent for Treatment

Please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the Office Manager. Thank you!

- **Insurance:** We are happy to bill both primary and secondary insurances as a ***courtesy*** for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, the contractual agreement is between you and your insurance company. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 30 days of receiving a statement.
- **Patient Payment:** The patient portion due for services rendered is expected **at the time of service** unless *previous* arrangements have been made. We accept cash, checks, money orders, and all major credit cards.
- **Financing:** We have financing options available through Care Credit. If you have an interest in these options, please consult with the Office Manager prior to the date of scheduled treatment.
- **No Shows/Missed Appointments:** We request notice to cancel or reschedule an appointment at least 24 hours in advance. If appropriate notice is not given, a charge of $50 may be assessed to the patient's account. For appointments scheduled for longer than 1 hour, an additional $50 will be charged for each hour missed, i.e.$100 for a 2 hour appointment, $150 for a 3 hour appointment.
- **Refunds for Unfinished Treatment:** If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the Office Manager and/or Dentist.
- **Credits on an Account:** If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.
- **Balances.** Balances unpaid after 30 days from the date of billing are subject to a finance charge at a rate of 3% per month (37% per annum).
- **Collections:** On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorneys fees, and any other costs incurred to enforce collection.
- **Returned Checks.** A $35 fee will apply for all checks returned for insufficient funds or closed accounts, and may prevent us from accepting checks as a form of payment for your dental treatment in the future.
- **Right to Discontinue Treatment:** I understand that Affinity Dental has the right to discontinue my care for any appropriate reason, such as excessive missed appointments or lack of compliance. The patient or patient's representative agrees to accept full responsibility for pursuing alternate professional dental care. All records are the property of Affinity Dental. Records/x-rays may be duplicated upon written request and a reasonable fee.
- **General Dentistry Informed Consent for Treatment** includes but is not limited to: Extracting teeth, Dental implants, Dentures or partial dentures, Local anesthesia and medicines, Restoring teeth with fillings or crowns, bridges, veneers, inlays, or onlays, Root canals. I understand that specific informed consents may be made available for any or all of the above procedures. I understand that dental treatment contains no guarantees, warranty, or assurance of success.
- **Risks:** All dental procedures have certain risks; including possible side effects from medicines used. The risks include, but are not limited to: allergic reactions, cuts/abrasions, tenderness/bruising, and tooth sensitivity.

I hereby give permission for diagnosis and /or treatment at Affinity Dental for myself or minor child below. I acknowledge that I have read the above information and have been provided with an opportunity to ask questions about its content. I accept full financial obligation for the services received by the dental professionals at Affinity Dental.

Patient Name: ______________________________

Financially Responsible Person: ______________________________

Signature of Financially Responsible Person: ______________________ Date:____________