



Financial Practices & Consent for Treatment

FINANCIAL PRACTICES

We are committed to partnering with you in the health and well being of your mouth. As such, we feel it important that our financial arrangements and treatment decisions are directly with you, and are not dictated by any third party. Ours is a "fee for service" practice, which means that we request payment at the time services are rendered. In addition to cash and checks, we accept VISA, MasterCard, Discover and American Express, and, in certain pre-approved cases, you can pay your obligations over time. We also have a relationship with a financing company that can assist you, after qualification, with paying for your dental needs.

RESCHEDULING FEES

We are grateful to have a thriving practice, and are often booking clients in excess of four weeks in advance. In addition, we pride ourselves on dedicating our undivided attention to our clients during their appointment. We also understand that our clients are up to great things, and will sometimes have changes in their schedule.

We request at least 48-hours notice if you need to reschedule an appointment, except in emergency circumstances such as a car accident or severe illness. Should you provide less-than 48-hours notice, we will make every effort to fill the time with a client who desires to come in sooner. If we are unable to fill the appointment, there will be a rescheduling fee, as indicated below. We reserve the right to request payment for appointments in advance.

Please initial below, indicating that you understand and agree to the following rescheduling fees:

Type of treatment	Rescheduling fee	
Regular perio-maintenance or prophylaxis (teeth cleaning):	\$100	
New Client Experience	\$108	
Treatment with Dentist totaling \$250 or under	\$150 or cost of appointment if under \$150	
Treatment with Dentist totaling \$251 - \$1500	\$150-\$450	
Treatment with Dentist totaling \$1500 or more	\$500-\$750	
Whiten and Enlighten	Cost of treatment	

Please provide credit card information.

We will alert you if your account incurs a rescheduling fee before processing such fees.

TYPE OF CARD: VISA MC AMEX DISCOVER

CARD NUMBER _____ EXP DATE _____ V CODE _____

NAME ON CARD _____

If you accrue an outstanding balance, and if it remains unpaid for 30 days, your account may be sent to a collections agency and reported to the associated credit bureaus; in such event, you are responsible for any fees charged by the collection agency to collect your unpaid balance.

Please indicate your understanding and acceptance of these financial practices, and authorization to charge the card you provided for rescheduling fees, by signing below.

Client Signature

Date

INSURANCE

While it is not necessary that you have dental insurance to be our client, if you do have dental insurance, we will help you get the most from that insurance. We will fill out your insurance forms for you, and submit them on your behalf; the insurance company will then reimburse you directly in accordance with your policies' allowances. If you would like to have us assist you in this regard, you must provide us with the dental insurance policy number, insurance company name, address and telephone, as well as the insured's name, birth date, social security number and employer information in the intake interview.

If your dental insurance is issued through your (or your spouse or partner's) employer, we recommend that you contact someone in that employer's Human Resources department if you are interested in finding out just what your insurance covers. If you do not have a Human Resources department, you may directly contact your insurance company to find out this information. Most insurance policies cover a significant portion of routine maintenance such as teeth cleanings, and most have relatively low yearly maximum benefits, but the amounts and services covered vary from plan to plan. The important question is whether your insurance allows you to choose your own dentist (this is called a "PPO"), or whether you may only see a dentist that is a member of a specific plan (an "HMO"). An HMO plan will only accept claims from a pre-approved HMO provider; we are not signed up as a provider under any HMO plan. All PPO plans allow claims to be submitted by the dentist of your choice; we are happy to prepare and submit claims to any PPO plan on your behalf.

INSURANCE INFORMATION (Address and phone number REQUIRED)

Name of Insured: _____ Insured's Birth Date: _____

Subscriber ID #: _____ Insured's Group No: _____

Insurance Plan Name: _____ Insurance Plan Phone: _____

Insurance Plan Address: _____
Street City State Zip

Insured's Employer _____

Employer Address _____
Street City State Zip

CONSENT

I affirm that the information provided in my intake interview and documentation is complete and correct to the best of my knowledge. I understand that this information will be held in strict confidence under all applicable laws and agree to promptly inform this office of any changes in my medical or personal status. In the event of a dispute regarding services or fees that the parties are unable to resolve, I agree that such dispute will be submitted to binding arbitration in accordance with American Arbitration Association rules, with each party bearing its own costs and fees, and irrevocably waive my right to have any dispute adjudicated by a court of law or jury. I consent to and authorize Dr. Fred Pockrass and staff to perform any and all necessary dental diagnoses and treatment.

Client Signature

Date

If the client is a minor, a parent or legal guardian must sign.

Parent or Legal Guardian

Relationship to Client

Date

We Look Forward to Serving You !