HICKS DENTAL
CONSENT FOR DENTAL TREATMENT

The undersigned hereby authorizes the Doctor to take study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I understand that my dental insurance is a contract between me and the insurance carrier and **NOT** between the insurance carrier and the doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental feels incurred. I understand that in the event the insurance check is mailed to me instead of the Doctor, I am to forward that payment to the dental office within, but no later than 10 days. I also acknowledge that cashing insurance checks for dental treatment completed and not paid constitutes fraud and legal actions will be taken to collect and I will be responsible for all legal fees incurred.

_____ _____

DATE SIGNATURE

_____

PRINTED NAME

HICKS DENTAL FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- **Payment** is expected at time of services rendered. Prompt payment allows us to control cost. We do not offer "in house" financial arrangements. If financial arrangements need to be made, we will assist you with processing a credit application to be submitted to an outside finance company.

- **Insurance** is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company at the time of service as a courtesy to you. It is YOUR responsibility to remit payment for charges not covered by your insurance and assure your carrier remits payment. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You will be responsible for any balance not paid by your insurance company within 30 days of service date.** You will receive a statement by mail and payment is expected by due date indicated on your statement.

- **Divorce**- In case of divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

- **Past due accounts** – If your account becomes past due, we will take the necessary steps to collect this debt**.** A **$25.00 re-billing fee** will be imposed every month on each account that is over 30 days past due and every month thereafter until the balance is paid in full. All patients refusing to remit payment after 61 days of notice will force us to suspend all treatment until the balance is paid in full. We also reserve the right to pursue collections of money owed which may include but is not limited to: outside collection agencies, credit bureau reporting, and legal action. You will be responsible for any fees incurred with collection of your debt.

- **Returned checks**- There is a fee (currently $25) for any checks returned by the bank.

- **Effective Date**- Once you have signed this agreement, you agree to all of the terms and conditions contained herein and agreement will be in force and effect.

Our office firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Our staff is instructed to make every effort to clarify any misunderstanding you have concerning your balance.

I have read and understand the financial policy of Hicks Dental. Any questions I have concerning this policy have been explained by the office staff.

Patient/ Guardian Signature: _____

_____ Date _____

Patient Printed Name

HICKS DENTAL APPOINTMENT POLICIES

Due to a significant increase in the amount of broken appointments, we find it necessary to implement the following policies.

1. A "**broken**" or **failed"** appointment is any appointment not cancelled with at LEAST 24 HOURS notice. Broken appointments prevent us from seeing another patient in the time reserved especially for **YOU.**

2. After the first failed appointment, you will be reminded of our policy. We are aware that emergencies do occur which prevent you from keeping your appointment. Please contact our office as soon as you realize you cannot fulfill your appointment. If it is after hours, you may leave a message on our answering machine. Please include your name, date and time of scheduled appointment, and a call back number where you may reached.

3. After the second and subsequent failed appointments, we reserve the right to charge a broken appointment fee. Fees will be applied as follows:

Hygiene: $25.00 per half hour reserved

Dental Treatment: $50.00 per each half hour reserved

These fees will be charged per person appointed. Please note that insurance companies will not pay broken appointment fees. Charges that have been billed must be paid prior to any further appointments being made for any patient on your account.

I UNDERSTAND THE APPOINTMENT POLICIES OF HICKS DENTAL AND AGREE TO ABIDE BY THEM. ANY QUESTIONS I HAVE ABOUT THESE POLICIES HAVE BEEN EXPLAINED BY THE OFFICE STAFF.

_____ _____

Patient Signature **Date**

_____ _____

Patient Printed Name **Date**

PAYMENT OPTIONS

We at **Hicks Dental** are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible. To assist you with your oral healthcare investment, we provide the following payment options:

Payment Options:

1. You choose to pay by **cash**___, **check**___, or **credit card**___ (Visa, Master card, American express) on the day that treatment is rendered. **WE DO NOT TAKE DISCOVER**.

2. On treatment involving laboratory fees (crowns, bridges, dentures, ect.) you are expected to pay 50% on the preparation date, and the remaining balance in three weeks.

3. On extensive treatment, you may prefer to secure a bank, credit union, or other third party financing for the entire amount and may make payments to the lending institution.

4. We offer special financing through **CareCredit**, subject to credit approval. If you pay them within 12 months, there will be no interest charge to you, as this is a courtesy provided by Dr. Hicks; however, anything over 12 months requires an 11.9% fixed interest rate to you. (13 to 60 months.)

5. **CareCredit-**-- is the financing plan we offer as a separate line of credit to cover you and your family members' dental needs. With CareCredit:* you enjoy these benefits:
   - Flexible financing options
   - Credit decision usually only takes a few minutes
   - No annual fees or prepayment penalties

We are happy to provide you the above payment options and are pleased that you have chosen to become a member of our client family at Hicks Dental.