INFORMED CONSENT AND NOTICE TO ALL PATIENTS FOR SERVICES

I understand that the information is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs, cleanings, fillings, crowns, local anesthesia and/or any other diagnostic aid deemed by the doctor to make a thorough diagnosis.

I also authorize the doctor and his employees for assistance when applicable to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. I hereby authorize Dr. Prost to retain all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I also assign all insurance benefits directly to Dr. Prost for services rendered.

Financial Policy

1. It is our policy to make definite and clear financial arrangements prior to beginning any treatment. We are in-network and/or a participating provider with some insurance companies, but not all of them. We will help you to maximize your dental benefits in our office.
2. Our fees are reasonable and customary for quality of care in this area, but as different insurance companies use different fee schedules (which vary greatly) we may or may not fall within what they consider to be usual and customary. You are responsible for paying all charges not covered by your insurance company.
3. Please remember that insurance is a contract between you and the insurance company. Despite verification by phone or written pre-authorization, your carrier may still deny payment on a claim.
4. We accept cash, debit, Visa, Mastercard, Discover, American Express and CareCredit. There is also a $35 fee for returned checks.
5. Often times patients find it to be convenient for them to keep a credit card on file for balances over 60 days to be charged to. Is this something you would like to do? YES/NO If yes, please provide CC# and Expiration Date below:

6. As a courtesy to our patients as well as our office staff, we require **2 business days' notice for all changes to your appointment(s)** (Business hours are Monday-Friday 7am-5pm). For example if your appointment is on Monday, you must make any necessary changes before closing time (5pm) Thursday. Any appointment that has any change made to it without **2 business days' notice** will be subject to a charge of **$50 per hour** that the appointment was scheduled. Please remember that your valuable appointment time may be needed and greatly appreciated by another patient. Your cooperation with this policy is very much appreciated.
7. I understand that payment is due at time of service. If for any reason your account is turned over to an outside collection agency due to non-payment of your account balance, all collection agency fees and any additional costs associated with the collection of your account balance will be added to the total amount owed.
8. The parent or guardian who brings a child for an appointment is responsible for paying the patient portion and any prior balance at that visit.
9. If collection efforts are needed, I agree to pay all reasonable costs of collections without limitation, attorney's fees and court costs.

By signing below, I acknowledge:

1. **I have read the above conditions of treatment and payment and agree to their content.**
2. **I have read, understand and accept the conditions of this financial policy. I have also received a copy of this policy for my own records (If requested).**
3. **I understand that I am financially responsible for all charges, whether or not paid by insurance.**
4. **I authorize Fletcher Heights Dental Care, PC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also authorize release of any information, including diagnosis and the records of any or examinations rendered to my dependent or me during the period of such care to third party payors and/or health practitioners.**

If opted, I authorize Fletcher Heights Dental Care, PC to charge balances over 60 days to the credit card on file that I have provided above.

_____
Patient Name (Please Print)

_____
Signature of patient, parent or guardian

_____
Date

_____
Signature of Fletcher Heights Dental Care, P.C Staff

_____
Michael A. Prost, DDC Fletcher Heights Dental Care, P.C