Paul Binon dds_msd
and associates IMPLANT DENTISTRY & PROSTHODONTICS

CONSENT FOR SERVICES/PROCEDURAL GUIDELINES

Thank you for choosing our office to provide you with quality dental care. Our office is committed to providing state of the art dentistry and excellent patient care.

By Reading and signing this form, you are acknowledging that you understand and consent to our office policies and procedures. Please inform one of our staff members if there is anything you do not understand or agree with before returning the signed document.

ALL PATIENT PAYMENTS ARE DUE IN FULL AT THE TIME OF SERVICE, UNLESS PREVIOUS PAYMENT ARRANGEMENTS ARE MADE.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Accepted methods of payments are cash, checks, Visa, MasterCard, American Express, and bank debit cards with the Visa or MasterCard symbol. Please note: There will be a $50.00 collection fee added to ALL PAST DUE ACCOUNTS. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days regardless of insurance reimbursement.

INSURANCE BILLING

Please understand that your dental insurance coverage is a contract between you, your employer and your insurance company. Please read your policy carefully and be aware of any exclusions and or limitations. Our office will not be responsible if a claim is denied due to your policy. All treatment is dictated and diagnosed by the condition of your mouth and will not be dictated by your insurance company's exclusions and limitations. Our fees for treatment are considered Usual, Customary and Reasonable, which mean that the fees are within reason for this geographic area.

Patients who carry insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

LATE CANCELLATIONS OR MISSED APPOINTMENTS

This office requires a minimum of 24 **hour's** notice when making any changes to an existing appointment. A fee will be automatically charged if you do not give appropriate notice. The amount of the fee is case specific, depending of the provider for the appointment and the time reserved for your care. The minimum cancellation fee is **$50.00.**

I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the time the estimate was given.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within 30 days of billing if credit is extended. I further agree that the reasonable value of said service shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I am aware that the Dental Materials Fact sheet and the Privacy Policies will be made available to me upon request. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to my dental treatment, appointments and/or this form.

I hereby authorize Dr. Paul P Binon and whomever he may designate as his associate, hygienist and assistants to perform all necessary procedures, and administer anesthetics and analgesics, related to the examination, diagnosis, and treatment to be performed. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances.

The nature, purpose, and risk of the procedures and possible alternative methods of treatment will, or have been, fully explained to me. I understand that there is a possibility of complications developing during or after any type of dental treatment. These include but are not limited to pain, numbness, tooth and soft tissue sensitivity, de-vitalization of teeth, infection which may require antibiotics, tissue recession, cuts, or injuries to the soft tissues which include lips, gums, cheeks, and tongue, fracture of teeth, damage to a health tooth, allergic reactions to materials used in the temporary and final restorations, and allergic reactions to anesthetics, medications and materials used in diagnosis or treatment. The nature, purpose, and risks involved in the use of anesthesia and medications have also been explained to me. Further I consent to the disposal of any teeth, tissues, or restorations (fillings - bridges etc.), which may be removed.

I agree to provide complete and current information on my medical condition. This includes: any and all drugs, medications, hospitalizations, past and present medical disorders, and any condition for which I have consulted a physician or health care practitioner. I understand the need for these questions to be answered truthfully. All questions have been answered truthfully and in my own hand.

I have read the above and I accept responsibility for these or any other complications, which may arise or result during or following the procedures, which are to be performed at my request. I have not been given or received any guarantees as to results to be obtained from treatment. I am now giving my free and voluntary informed consent for the treatment to be rendered. I agree that if I fail to co-operate fully with the doctor and staff, my treatment can be discontinued at any time.

SIGNATURE _____ DATE _____

(Patient or Parent if patient is a minor)