**PATIENT AGREEMENT**

**INFORMED DENTAL CONSENT**

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures and all of your questions have been answered. Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to one’s body, including dental treatment, there are no guarantees that the results will be as planned and to each individual’s satisfaction. When dealing with the human body there are many variables involved, some predictable and others are not. Complications in dentistry are very low but they do exist. Even a minor procedure like a simple ‘filling’ can lead to major complication that can’t be foreseen. For example, a ‘Novocaine’ or local anesthetic injection could lead to an allergic reaction, anaphylaxis shock, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are very uncommon occurrences but individuals who are contemplating treatment should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems. I understand that as treatment progresses, Dr. Barrows may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

**I have read and understand Informed Dental Consent and the provided Consent Form of Possible Services and I consent to the proposed dental treatments.** Initials \_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY**

**Dental Insurance Coverage:**

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We can request a pre-estimate of benefits from your insurance carriers if you request us to do so. The insurance estimates we provide are a courtesy to our patients and in no way are we to be held responsible for what your insurance carrier covers or does not cover. Remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute of payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs if such actions are necessary to collect unpaid account balances. We accept payments from some insurance companies. If you have insurance, please provide your card at check in so we can process the paperwork while you are being seen by the doctor. We will send the claim form to the insurance for you. Please keep in mind that we are considered **OUT OF NETWORK** for **ALL** dental insurance. Any portion that is not fully covered by your insurance will be the patient’s responsibility and a statement will be sent. Understand that insurance companies use their own fee schedules based on fees paid to in-network providers and that your insurance coverage table percentages are based on average and customary fees for the U.S. and because we are considered an international location the coverage amounts will vary. **Initials \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**

**All Patients With or Without Insurance:**

All procedures involving lab work will require a 50% down payment, and the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion. We accept cash, Discover, American Express, Visa, MasterCard, and debit cards. **WE DO NOT ACCEPT CHECKS AS A METHOD OF PAYMENT**. PAYMENTS IN FULL for your portion are required the day service is rendered. PRIOR PAYMENTS may be required for any major dental procedure(s). A treatment plan with projected costs will be provided.

**The office of Dr. Michael Barrows does not offer any payment plan options and/or any refunds for dental treatment started and/or completed. You may discontinue treatment and request a refund for dental treatment that was pre-paid and does not interrupt current dental services/procedures that are in progress.** Initials \_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

**OFFICE POLICY ON SCHEDULING APPOINTMENTS**

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. For any appointment(s) broken without a 24 hour cancelation notice and any NO-SHOW appointments may result in a $35 fee. Continuous missed appointments and canceled appointments will result in the termination of our dental services rendered to you . **Initials \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**

**I, (PRINT NAME),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the Patient Agreement above and agree to the terms set forth.**

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient** (Parent or Guardian if Minor) **Date**