

Shane R. Costa, DDS, PC

CONSENT FOR SERVICES

I (or authorized representative/guardian) hereby authorize Dr. Costa to take x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Dr. Costa to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication. I hereby give Dr. Costa the absolute right and permission to use my photographs for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs.

I have read and understand the above information.

Patient, Parent or Guardian: _____ Date: _____

FINANCIAL POLICIES

We are committed to providing you with the best possible dental care. In order to begin a long lasting professional relationship, we ask for your understanding of and cooperation with our financial policies.

PATIENTS OF METLIFE, DELTA DENTAL, GUARDIAN, AETNA, UNITED CONCORDIA AND ANTHEM PPO.

As a contracted provider for these plans, we will submit your claims and receive corresponding payments. You will be responsible for making any estimated co-payments at the time of service. We will be happy to submit your insurance and collect payment from them provided we have verified eligibility. Estimated co-payments, however, will be payable in full at the time of service. Any remaining balance after the insurance payment has been received will be due upon receipt of statement.

ALL OTHER PATIENTS:

Full payment is due at the time of service unless other arrangements have been made in advance. "Other arrangements" are per occasion and are not to be considered permanent arrangements. Financial alternatives for extensive dental treatment can be discussed and approved by our office manager.

OTHER IMPORTANT ITEMS:

- 1) When appropriate, we will be happy to submit a pre-treatment estimate to your insurance at your request and after you have provided appropriate insurance information.
- 2) Accounts exceeding 90 days since the last payment will be reviewed for collection by a third party. **If you receive a statement you do not understand, please call us immediately. DO NOT IGNORE the statement.** Communication is key to our relationship.
- 3) If an account requires collection by a third party, all attempts to collect your debt will be done by the collection agency. We sincerely hope these measures will never become necessary.
- 4) Unpaid insurance claims exceeding 90 days or after multiple attempts to file with the insurance carrier will become the patients responsibility and you will be required to pay the balance in full.
- 5) **A \$75 fee will be charged to your account for each missed appointments and appointments canceled without 24 business hours prior to notice. Appointments that were scheduled for more than one hour will be charged at a rate of \$75 per hour.** We appreciate your respect for other patients who can utilize your reserved time and your respect for our time. We extend the same courtesy.
- 6) Prosthetic cases (crown, bridge, veneers, etc.) as well as Invisalign and cosmetic bleaching will not be delivered until final payment had been received or financial arrangements are on file.
- 7) There will be a \$25 charge for all returned checks, payable by cash or credit card only. Checks which are not rectified immediately will be surrendered to a third-party collector for legal action.

If you have any questions concerning the above information, please do not hesitate to ask. We are here to help you!

I have read and understand the above information.

Patient, Parent or Guardian: _____ Date: _____