LAKEVILLE ADVANCED DENTAL CARE

FINANCIAL POLICY

Assignment and Release

I, the undersigned, have insurance with _____, and assign directly to Lakeville Advanced Dental Care all benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ **Signature:** _____
Signature of Patient/Parent/Legal Guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Lakeville Advanced Dental Care and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that for any treatment not covered by an insurance benefit plan, payment is due in full at the time service is rendered. I understand that **after 60 days, any unpaid balance will incur a $20 billing fee.** I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Initials: _____

Cancellation Policy

I understand that because appointments are not double-booked, I must provide notice of cancellation at least two business days prior to my scheduled appointment time. Failure to notify may result in a fee.

- A No Call-No Show or Same Day Cancellation will result in a $50 fee.
- After two No Call-No Shows, we will require a $50 deposit to schedule or reschedule any further appointments.
- Appointments three hours or longer will require a $200 deposit to reserve the appointment. If appointment is cancelled or rescheduled without proper notice of two business days, $200 deposit will be forfeited.

(Exceptions may be made based on extenuating circumstances.) If I am seen for my appointment on its regularly scheduled time or if I provide sufficient notice of cancellation or to reschedule this deposit will be applied towards my out-of-pocket investment in my dental health at Lakeville Advanced Dental Care.

Initials: _____

Date: _____ **Signature:** _____
Signature of Patient/Parent/Legal Guardian

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ **Signature:** _____
Signature of patient/parent/legal guardian