Patient Name: _____ Date: _____

Practice Patient Financial Policy and Consent

American Academy of Dentistry 2012 adopted…

Legislation to prohibit a dental insurer or dental service plan from limiting fees for services not covered under the plan, as contrary to public policy, was the law in over half of the states in 2011 and has been introduced in most other states, where eventual passage of most is generally assumed.

The House of Delegates of the ADA in 2009 adopted Resolution 59H which opposed third party contract provisions that establish fee limits for non-covered services and called for state and federal legislation to prohibit such practices. Federal legislation prohibiting all group health plans (including stand-alone dental plans and medical plans with dental benefits) from applying the plan's fee schedule to services for which no benefit or reimbursement is provided was introduced in 2010. Policy statement The AAPD believes that dental benefit plan provisions which establish fee limitations for non-covered services are not in the public's interest and should not be imposed through provider contracts.

Therefore, in the state of TEXAS dentist may:

"The Dentist may charge the covered person directly for services which are not covered services reimbursed in whole or in part by your dental insurance company or any other qualified entity, but only at the covered person's request and only after it has been explained to the covered person that the services are not covered and the covered person has agreed to receive those services at his or her own expense."

I_____, (print name) agree to the liability of any and all reasonable charges not covered by my insurance company even though they may indicate a different responsibility fee on the EOB than what was discussed and agreed upon with the practice staff. I understand that not all services that are presented to the insurance company that is custom, elected and I 100 % responsible financially for these agreed and communicated treatment, services or products thereof. However, I also understand in the midst of treatment there may be changes to occur and that are not a part of the treatment plan. The changes may occur while under sedation. These changes will be explain during treatment, upon completion and if requested aging in the near future. These changes in treatment are my financial responsibilities wither or not they are covered by the insurance company. I understand that if my insurance changes while undergoing treatment my fees may changes and/or financial responsibilities. I understand any and all services rendered to me are 100% my responsibility and I understand that Dr. Goodall's practice will assist me to get the benefits paid for from my carrier within a reasonable time. If claims are over 45 days old I am responsible to pay the balance of my account and then work with my insurance company to reimburse me. If the payment goes to Dr. Goodall and I have a credit. Dr. Goodall's practice will inform me of this credit to which I will choose to either leave on the account for future family treatment or to be reimbursed within 45 days of that that request.

I, authorize Dr. Goodall, to take x-rays, study models, photographs and other diagnostic aids appropriate to make a thorough diagnosis of the patient's dental needs at my financial expense. I also authorize the doctor to perform all recommended treatment "MUTUALLY AGREED UPON with the knowledge treatment may change once plaque, decay, crowns or other devices that maybe blocking visual diagnostics prior to the onset of treatment." I understand that removing prior placed restorations, large areas of decay and/or ortho devices may cause the teeth, bone and/or tissue around the area of concern to fracture, break or tear. Repair of the unexpected will be at my expense. I understand that using anesthetic agents embodies a certain risk, upon request I can be given a list of these risk to make a sound decision for my best care in moving forward with treatment. I understand and consent to the doctor's use of assistance employed by the practice or selected for my restoration, evaluations and other medical/dental concerns for my best dental treatment and special needs. I understand and agree to pay my **"estimated fees"** as they are rendered or mutually agreed major upcoming custom elected services. Any and all services not covered, downgraded, denied or difficult to collect from the insurance company will be paid within 45 days of treatment/service rendered. I understand that if I choose to use my **health savings credit card** not all services/treatment/products are covered by the program and the practice has no knowledge of what is liable with the use of the health savings card and I will pay the account in full immediately if card is rejected. I understand that if my account balance goes over 90 days I may be charged a finance and/or billing fee as well as turned over for collections. I may also incur a charge for no showing or being over 15 minutes late that could be a onetime fee of $40 or up to 50% of my treatment time scheduled. I understand that I need to give a 48 hour notice to request a change to my appointment. I understand that my insurance is an agreement between me, my insurance company and possibly my employer. The practice has no responsibility of changes, non-payment or in-depth knowledge of your plan or health savings accounts. I understand that if the practices choose to accept delayed payment by submitting all or part of my treatment to my insurance company the practice is doing so as a courtesy to the patients. I understand that the "ESTIMATED" service fees are only "estimations" and my change once the EOB is received from my insurance company, therefore, my fees and payment may change with that notification. I agree to be 100% responsible for any and all services, treatment, products rendered to family, household or me. I authorize insurance payments and proceeds for all treatment, services and products submitted to my insurance to be paid to the practice. The practice reserve the right to cancel any appointment that is not confirmed verbally or in writing, during poor weather, staff CE/vacation/sick or patient emergencies cause the schedule to make changes. These appointment cancelations and/or changes will be done as promptly as we can so that they do not hinder your schedule and/or plans to schedule.

I have read and understand the above information and agree to the terms and policy within. _____Yes _____NO

If you do not agree please print your name at the top check "NO" and please sign that you are denying service and/or contact our office to cancel your dental appointment. If you agree please check "YES", sign this document and move forward to the next page. Thank you.

_____ _____ _____

Patient/Guardian Signature Relationship to patient Date