Consent to Treat and Financial Policies

Thank you for choosing Heavenly Dental as your dental provider. We are committed to providing you and your family the best care possible.

Consent to Treat:
By signing, you consent to treatment in our office. This includes any examinations, tests, x-rays or other procedures which may be deemed advisable or necessary.

You will be notified of any such testing and you have the right to an explanation of any procedures and their risks, benefits, alternatives, and charges before they occur. Your signature here consents to these procedures.

It is your responsibility to inquire about and/or decline any such procedures. The occurrence of a procedure indicates that you understand the risks and benefits and have received a satisfactory response to your questions, if any.

Insurance:
If the patient is covered by an insurance plan that allows assignment of benefits, we will file your insurance claim for you. By signing below, you

- allow us to file this claim for you and assign all insurance benefits arising from the claim to be paid directly to our office.
- accept responsibility for any charges not covered by your insurance plan and which are legally billable to the insured; you accept full responsibility if your insurance is terminated or otherwise invalid.

If the patient is covered by a plan where benefits cannot be assigned we may provide you with the necessary documentation to file your own claim for reimbursement. In this case you are expected to pay the full balance at the time of treatment.

If we are unable to collect from your insurance company after 90 days we will collect the remaining balance from you and provide you with the paperwork necessary to submit on your own.
You will be financially responsible for ANY non-covered services

Policy on Missed Appointments:
Please give us two business days notice to reschedule an appointment. **If an appointment is cancelled within 24 hours of the appointment time, it will count as a missed appointment.** Missed appointments will incur a charge of **$25 per ½ hour of appointment time missed**. If you are 15 MIN LATE your treatment may be cancelled at our discretion, and it will be counted as a MISSED APPOINTMENT. This balance must be paid before any further appointments can be scheduled. If you need further information on this policy, please call the office.

I acknowledge that I have read and agree to the Consent to treatment, Insurance Assignment (if applicable) and Policy on Missed Appointments as written above.

First Name :_____ Last Name :_____

Signature_____ Date (DD/MM/YYYY)_____