AUTHORIZATION

YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE INDICATES THAT YOU UNDERSTAND AND AGREE TO ALL OF OUR POLICIES.

I authorize and give consent to the performance of dental services for myself (or my dependent).

I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I give this dental office the right to release any health information and x-rays relevant to my treatment to my insurance carriers, physicians or dental specialists that I may be referred to.

I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage.

Patient signature: _____Date: _____

FINANCIAL POLICIES

• **Full payment is due at the time services are rendered.**
We do accept assignments of your insurance benefits. However, we do require your co-payment and deductible be paid in full at the time of your appointment. The balance is your responsibility whether your insurance pays for your treatment or not. In the event that your insurance does not pay as much as we anticipate, you are responsible for the remaining bill. It is imperative that you inform us of any changes in your insurance coverage **PRIOR TO TREATMENT.**
Please be aware that not all services may be covered by insurance. The office cannot know all of the coverage limitations and rules of your plan. To avoid any miscommunication or billing disputes, please contact your insurance company before services are provided. It is important that you read and understand the provisions of your insurance.

Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help. **Any claims unpaid within 60 days of the date of service, becomes the patient's responsibility.**

For patients without dental insurance, you are requested to pay in full at the time of service. If payment in full can not be made at the time of service, payment arrangements must be made with the office manager in advance.

NO SHOW/ CANCELLATION POLICIES: If you do not cancel your appointment within 48 hours or do not show up for an appointment, you will be charged a fee of $50.00, which will be due prior to your next scheduled appointment.
If this appointment was scheduled with Dr. Zourdos, you will be required to pay the fee of $50.00 and pre-pay the estimated out-of-pocket amount of your next visit. This amount is non-refundable.
All **cancellation** and **no show** appointments are documented in the chart and become part of your record.
Payment may be made via Cash, Check, Visa, MasterCard, Discover and American Express.
There is a $30 + $5 bank fee for all returned checks.

NEW PATIENT PROMOTIONS: All patients referred by a "new patient" promotion such as Groupon, Living Social, Newsletter, Local Coaster, or any other discounted offer will be required to pay a fee of $45 in the event a copy of X-Rays and/or Patient Chart is requested by you, the patient.

I understand the above and agree that if full payment is not made within the two-month grace period, that I am responsible for any fees involved in the collection process, including, but not limited to, court cost and attorney fees in addition to the outstanding balance.

Patient Name_____

Patient Signature: _____Date: _____