Westborough Dental Associates

33 Lyman St., Suite 203A, Westborough, MA 01581

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Print Patient **Name ID #**

General Consent, Financial and Appointment Obligations

Ensuring that our patients receive the highest quality of care is the goal of everyone at Westborough Dental Associates. Our attention to detail and fine materials are second to none. We acknowledge that everyone's financial situation may be different therefore we offer a variety of payment options. For your convenience Westborough Dental Associates accepts most insurance plans. As a courtesy we will give you insurance estimates as well as file your insurance claims for you. Please remember that we can only give you an **estimate** and it is your responsibility to check your eligibility, maximums and allowances of your insurance coverage before you begin any treatment.

➢ **All** dental services and treatments are payable in full at the time of service *unless* prior written financial arrangements have been arranged. This includes any estimated insurance co-payments. Services that may include laboratory fees (crowns, bridges, veneers, dentures etc ...) require a sixty percent (60%) payment of the patient's total portion or co- payment the first appointment and the remaining forty percent (40%) due at treatment completion. An interest charge of 18% may be charged on any past due account balance past 30 days. This will help keep our costs down and ensure our ability to provide you with the best possible care for years to come.

➢ A deposit may be required to reserve longer appointments and will be applied to your account as credit towards any patient responsibility. This allows for us to give you our utmost attention in a timely manner.

➢ We truly understand our patients' schedules and daily lives are hectic, but in order to accommodate all of our patients needs, we kindly request a **48 hour notification** to cancel, change or re-schedule any appointments. If we are not personally available to take your call, messages may be left on our machine.

➢ Regarding **Diagnosis & Preventative Procedures:** I hereby authorize Westborough Dental Associates team members to perform all procedures deemed appropriate and necessary to aid in a thorough diagnosis of my dental needs or in attempt to prevent dental conditions. I understand this includes, but is not limited to X-ray films, patient photos, periodontal charting, diagnostic waxes or models of teeth, periodic dental exams and prophylaxis (cleaning), fluoride treatment and sealants. Upon diagnosis, I understand that I will have the opportunity for any questions regarding my treatment, risks, and/or complications to be answered by Westborough Dental Associates team.

➢ All payments are due at time of service unless payment arrangements have been made.

Disclaimer: Though Westborough Dental Associates will process dental insurance claims on your behalf a Dental Insurance Policy is a contract between you and your Insurance Company. Insurance coverage is only an estimate based on current, available benefits as provided to this office by you and your insurance company. Insurance companies reserve the right to pay, at their discretion, as of the date of service. The patient or Guarantor is responsible for all charges incurred by receiving treatment here. All reasonable efforts will be made by the team at Westborough Dental Associates to help you receive the maximum allowable benefit for your plan, but ultimately the account balance is solely the responsibility of the Patient or Guarantor.
I understand that any future proposed dental treatment and fees described to me are *ESTIMATES* based on the current treatment plan and my insurance(s) if any. I understand that for the purposes of estimating my treatment plan and any patient responsibility, Westborough Dental Associates has relied upon information obtained from myself and my insurance carrier, and that if this information deviates from actual policy coverage or if changes occur to my policy coverage before services are rendered, I am responsible for any amounts not covered by my policy. I also understand there are occasions where the diagnosis or recommended treatment plan may change and that this may result in changes to the expected cost of such treatment. I further understand that by signing this agreement does not obligate me to any treatment not rendered.

_____ **Date:** _____

Patient or Responsible Party Signature