

**Dr. Killian ( Welcome to our our Practice )**

Patient Name:

Birth Date:

Date Created:

**Insurance Information**

Dr. Killian is a non-participating provider for all HMO-PPO insurance companies. As a courtesy we will file claims with your insurance on your behalf. Our office will estimate and collect patient portions on the date of service.

**Employer Sponsored Dental Insurance**

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. Your dental insurance is a benefit provided by your employer. Usual, customary and reasonable (UCR) / Fee schedules differ with each insurance company, often those premiums are a negotiated costs between your employer and the insurance being offered. It is not uncommon to pay a portion for preventive care with some of these insurance companies. A certain policy may read preventive care covered at 100%. But actually it's 100% of any allowed fee.

We accept Cash, Checks, Visa, MasterCard, Discover, and American Express as well as Care Credit.

If you have any questions regarding Care Credit please speak with any of our staff members.

**Appointment Reminders**

Please be advised that our office requires at least 48 hour notice when changing your dental appointment. Our e-mails, texts, and phone calls are a courtesy reminder and not the time to change or cancel. Any last minute changes could best be served by other patients waiting to receive dental treatment. We do understand emergencies arise, in those cases please notify our office by calling as soon as possible. Do not send email/text to cancel your appointment. Chronic failed / re-scheduled appointments will be charged a fee of \$54.00 per half hour and future appointment times may not be reserved.

**Billing**

I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. Interest on the unpaid balance, at the rate of eighteen percent (18%) per annum, will be accrued 45 days after services rendered. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection fees incurred.

**Permission To Treat**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dental professional.

I hereby authorize payment of insurance benefits directly to the dentist group, otherwise payable to me.

**I HAVE READ AND UNDERSTAND ABOVE**

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_