SAUCONY SMILE
Family Den

Saucony Smiles
162 Trexler Ave, Kutztown, PA 19530
(610) 683-0454
www.sauconysmiles.com/

FINANCIAL POLICY

AUTHORIZATION LETTER/FINANCIAL POLICY

Please read the following paragraphs and sign your name in the appropriate place if you consent to treatment.

I hereby authorize and consent the office Saucony Smiles to the operations, procedures, techniques and clinical photographs that the dentists deems necessary for my care.

I understand that prior to any surgical or diagnostic procedure, technique, or taking of any clinical photograph, I will be advised by those responsible for my care, and that I may ask questions concerning the treatment. I also understand that post-operative complications (for example, bleeding, pain, swelling, loss of teeth) may be a normal consequence of the treatment rendered. I further understand that I may revoke this consent before such treatment is provided.

I understand that the course of treatment may need to change for a variety of reasons. Every effort will be made to inform you if a change becomes necessary.

I hereby authorize and consent the office of Saucony Smiles to release to government agencies, insurance carriers, or others who are financially liable for the dental care, all information needed to substantiate payment for such care, and permits other who are representatives thereof to examine and make copies of all records relating to such care and treatment. However, after disclosure has been made, it cannot be revoked retroactively to cover information prior to revocation. I understand this consent will remain in force until I revoke it in writing.

I hereby state that I have read and understand this consent form, and that I have been given the opportunity to ask questions, and that all my questions have been answered in a satisfactory manner.

Assignment of Benefits

I hereby authorize payment of benefits to the undersigned supplier for services. I hereby authorize the release of any information necessary to process claims. I hereby authorize payment directly to the office of Saucony Smiles. I understand that I am responsible for charges not covered by my insurance plan.

Privacy Practices

I hereby state that I have read the Notice of Privacy Practices for the office of Saucony Smiles.

Medical History

I hereby state that the information I provided for my medical history to be true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health, and that is my responsibility to inform the dental office of any changes to my medical status.

Financial Agreement

A $35 fee shall be charged for all retuned checks. If you have a past due balance, you will be required to make payment on this prior to being seen. It is our policy that when an account is past due for 3 statements you will receive a finance charge of $10, after 4 statements, it will be referred to our collection agency. If referred to collections, you will be responsible for a collection fee.

*******3% Surcharge for CREDIT CARD transactions. No fee for cash, check, or debit card.*******

Appointment cancellation must be received 24 hours prior to scheduled appointments. A fee of $35 will be charged for cancellations or no shows.

For whom consent for treatment is granted

Signed (patient of parent/guardian of minor)/Date_____

Patient's signature: Date: