

Artistic Dentistry Office Policies

Financial Policy

Treatment cost estimates are provided to you, the patient, prior to treatment. We do file insurance claims on your behalf; however, your copayment is due at time of service. Although we file insurance claims for you, the ultimate responsibility of your bill is you. If after 60 days, no payment is received from your insurance company, payment in full is due from you. All accounts over 90 days will be subject to an 18% per annual finance charge. Accounts unpaid after 120 days are sent for collections.

Initial and date: _____

Cancellation Policy:

I understand a \$45 fee will be assessed to my account should I fail an appointment without 2 business days notice.

Initial and date: _____

Acknowledgement of Receipt of HIPPA compliance:

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

Initial and date: _____

Prosthetic Policy:

In the event that any treatment involving crown, bridge, partial, or denture appliance being made on my behalf; if treatment is not completed (appliance delivered to me) within three months from prep date, I will be responsible for the entire fee regardless of my insurance status. *(Most insurance companies pay dental claims for crowns, bridges, and dentures only after the appliance is delivered to the patient).

Initial and date: _____

Local Anesthetics

The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate which will return to normal. Common complications that can occur from local anesthetic include but are not limited to pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness.

Initial and date: _____

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures due to condition found while working on the teeth that were not discovered during the initial examination. I give permission to Dr. Wasselle to make any/all changes and additions necessary once I have been informed of these changes and consented to them. I also understand that not following my dentist's recommendation or delaying treatment may lead to but not limited to discomfort, increased complexity of the treatment outcome, and even loss of teeth.

Initial and date: _____

Patient Signature: _____ **Date:** _____