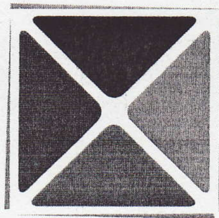

Dear Patient,

Thank you for choosing Metro Square Dental Associates. We would like to discuss some key issues that will relate to your care in our office. Please read through the following and initial after each one. If you have any questions, please feel free to step up to the desk and ask any of us to explain. Thank you for your time.

- I understand it is my responsibility to know my contracts, limits, exclusions, and annual benefit maximums with my dental insurance, and that I am ultimately responsible for payment regardless of what my insurance pays. If my insurance does not pay within 90 days, I will be responsible for payment in full, and can obtain reimbursement from my insurance on my own _________.

- I understand that I am responsible for my estimated portion, at the time services are rendered, unless a prior financial arrangement has been made. Metro Square Dental Associates will estimate my portion to the best of their ability, but my insurance company holds the ultimate say in what I pay out of my pocket _________.

- I also understand that Metro Square Dental Associates does not base treatment on insurance coverage. The office bases treatment on the needs of each individual patient. If I would like the office to send an estimate for treatment prior to having it done, I will request that it be done, and I will follow up with my insurance company _________.

- Metro Square Dental Associates considers every patient equally as important as the next. Therefore, if I cannot make my appointment I will give at least 24 hours notice so the office can allow another patient to take my place in the schedule. I understand that a fee will be charged if I do not give proper notice ________.

- Metro Square Dental Associates uses a courtesy automated phone call reminder system. I understand that this system will call me at least two days prior to my appointment to remind me, but I will keep track of any appointment, as the phone call is a courtesy ________.

I have read and initialed the above, and I understand these key points.

Patient Name: ______________________________ Date: ____________

Signature of Patient or Parent/Guardian: ________________________

Making Every Treatment Result Outstanding

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