Consent for Services

I understand and agree to the following office policies set forth below for services rendered by Dr. Walter and/or His Professional Staff. We appreciate the opportunity to serve you. Please feel free to address us with any questions about your treatment.

- **The practice depends upon reimbursement from the patients for the costs incurred in their care. Therefore, the patient is responsible for all services rendered regardless of what the insurance does or does not cover.**
- **Patients carrying Dental Insurance understand that all dental services furnished are charged directly to the patient and he or she is personally responsible for payment of all Dental services. This office will help prepare the patients insurance forms, assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.**
- **This office will bill my Ins. Company through a computer-generated claim; However, I understand I must provide them with a yearly-signed and completed claim form.**
- **All patients having Delta Dental, United Concordia or any other Insurance Company that pays directly to the patient understands that payment is due on the date of service and the insurance company will reimburse you directly. This office will send out the initial claim, but I understand that it is my responsibility to follow up with said Insurance Company if they do not reimburse my claim. I further understand that because My Insurance Company pays to me, Dr. Walter's office may or may not receive an Explanation of Benefits (EOB) from the Insurance Company.**
- **Anyone having Insurance that pays directly to this office understands that they are responsible for their estimated portion on the date of service. This estimate is not a guarantee of payment. Any difference in this estimate and what the insurance covers is due within 30 days of Insurance Payment.**
- **If I am not covered by Insurance, I understand all services are due and payable at the time service is rendered.**
- **All emergency visits must be paid in full at the time of service REGARDLESS of Insurance Coverage. I understand that this office will bill My Insurance Company for me and I can request reimbursement for any emergency service that was covered.**
- **I understand that 50% is required when services are started for All major procedures such as Crowns, Bridges or Root Canal Therapy. The remaining balance is due before being seen for the completion of these services. This is for Insurance and Non-Insurance Patients.**
- **If I present myself, a child or another party to this office and someone else is responsible for payment of the dental services, I understand that I must pay on the date of service. I can request a receipt to get reimbursed from Responsible Party.**

Thank you for the opportunity to serve you. Please feel free to ask us any questions at anytime. We appreciate mutual open communication and appreciate your trust in us.

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Signature of Patient/ Parent or Guardian Date Relationship to Patient