CHAMBERLAIN
DENTAL HEALTH

Patient Conditions of Treatment and Financial Agreement

This document is an agreement between David M. Chamberlain, DDS, PC and the Patient and/or the Patient's Guarantor ("You"). In consideration of the dental and applicable health care services provided to you by David M. Chamberlain, DDS, PC, you agree as follows.

1. **CONSENT FOR TREATMENT**: You consent to dental and applicable health care, including x-ray examination, anesthesia, dental, medical, surgical, and/or diagnostic treatment by David M. Chamberlain, DDS, PC, its dentists, hygienists, dental assistants, and staff, as directed by the patient's dentist, or consultants selected by that dentist. You understand that the practice of dentistry is not an exact science and that diagnosis and treatment may involve risk of failure or injury. You acknowledge that no one has made any guarantee to you about the result of treatment or examination by David M. Chamberlain, DDS, PC.
2. **FINANCIAL AGREEMENT: You agree to pay your bill in full at the time of service**. If you have **dental insurance** you agree to pay your **"co-payment" at the time of service**. You will be charged the established fees of David M. Chamberlain, DDS, PC, or the contracted fees that pertain to your particular PPO plan, of which David M. Chamberlain, DDS, PC has previously negotiated. Payment options, including CareCredit and other extended payment plans, must be discussed and arranged with the business office **prior** to treatment. Acceptable forms of payment are cash, check, Visa, MasterCard, American Express, Discover Card, cashier's check or money order. In the event that David M. Chamberlain, DDS, PC refers your account to a collection agency, a collection fee of **50%** will be added to the principal balance. **YOU** agree to pay all applicable collection and/or attorney's fees and expenses. And, you agree to pay 1.5% interest per month if your account becomes more than 60 days past due.
3. **INSURANCE SUBMISSION AND ASSIGNMENT OF BENEFITS**: You authorize David M. Chamberlain, DDS, PC to submit, on your behalf to your dental insurance company for payment of dental care services. You confirm that the information you have provided to allow the office of David M. Chamberlain, DDS, PC to submit for payment to your dental Insurance Company or Benefit Carrier is correct. You authorize your Insurance, dental plan, statutory benefits, settlements and judgments to which you are entitled in connection with your dental services to be paid directly to David M. Chamberlain, DDS, PC. You agree that you are financially responsible for charges that are not covered by this assignment, and that **you** are responsible for satisfying any conditions necessary for insurance payments and/or dental benefits.
4. **INSURANCE PLAN RESTRICTIONS**: You understand it is your responsibility to contact your insurance company regarding your plan benefits and exclusions. Exclusions may include, but are not limited to deductibles, waiting periods and insurance company limitations that are specific to your plan. Also, whether the doctor you are scheduled to see is a provider for your plan, whether certain tests or treatments are covered benefits, and if your plan requires a referral before seeing a specialist. Some plans have reduced benefits for restrictions, while others simply refuse to pay if you receive services outside of your contract. You are responsible for all deductibles and charges not covered by your insurance, as specified in your insurance plan contract.
5. **SECONDARY INSURANCE**: Having more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. Secondary insurers have specific guidelines, stated in your contract with them, for what they will consider for payment in coordination with your primary insurance payment. We bill your secondary carrier as a courtesy. **You** are responsible for any balance owing after your insurers have paid. If your insurance carrier(s) do not pay after submission and within 45 days, we may thereafter consider the balance due your responsibility.
6. **DIVORCE DECREES**: This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult(s).
7. **MINOR PATIENTS**: The adult parent(s) or Guardian(s) accompanying a minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless services have been pre-authorized by the parent(s) or guardian(s) and payment has been made before or at the time of service in accordance with item number 3 above.
8. **LABORATORY, SPECIALIST AND FACILITY REFERRALS**: during the course of treatment, your doctor may find it necessary to order additional tests or refer you to a specialist for treatment. David M. Chamberlain, DDS, PC will make every effort to comply with your insurance plan's guidelines; however, it is your responsibility to inform us of any referral restrictions. It is your responsibility to verify that your insurance plan allows you to see the specialist or physician service we refer you to. Our experience has been that, even with an "approval" from a pre-certifying entity, insurance company authorizations are not always a guarantee of benefits. David M. Chamberlain, DDS, PC will not be held responsible for decisions your insurance plan makes retroactively. Fees and insurance contracts of facilities and physicians not employed by David M. Chamberlain, DDS, PC are under separate contract and David M. Chamberlain, DDS, PC will not bear responsibility in any way.
9. **RETURNED CHECKS**: If a check has been returned to us by your financial institution for insufficient funds, David M. Chamberlain, DDS, PC will reverse the payment amount and add a $20.00 service fee to your account to cover our costs.
10. **BROKEN APPOINTMENTS**: When you make an appointment, we reserve an increment of time for your dental procedure(s). When you miss your appointment, it then becomes wasted time that Dr. Chamberlain could use to see another patient. We ask you to be courteous of our time and yours. Please give us 24 hours notice if you need to cancel your appointment. We reserve the right to charge a $10.00 missed appointment fee if not cancelled prior to 24 hours.

By signing, you indicate that you have read, understand, and agree to these terms. And, that you have received a copy of this document, and that you are the patient, guarantor, patient's legal representative, or legally authorized signer.

Patient name (Please print)______________________________ Date_____/______/______

Signature of Patient or Legally Authorized Representative______________________________

Other family members we may see that this document pertains to:______________________ ______________________

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