INSURANCE / FINANCIAL AGREEMENT

Thank you for choosing Cosmetic Dentistry of Baton Rouge. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible. We will gladly file your insurance and keep you informed of the status of your claims. Insurance companies may assist you in a portion of your treatment, but is not intended to cover the entire fee. Regardless of which insurance company you have, we will be more than happy to file the claim for you. In the event your insurance company will only send reimbursement to you, it is expected that you pay your appointment in FULL at the time of service. If the doctor determines that an additional procedure is required, you will be informed immediately and financial arrangements will be made for that service. If your insurance company does not pay the estimated amount as expected, we ask that you pay your remaining balance within 30 days of notification.

If your insurance company pays more than we anticipate, we will gladly refund the difference or you may leave it on your account. Our office will call you to make this decision. Refunds are issued once a month and will be made payable to you in the same method as the original payment.

Although we do work with insurance companies on your behalf, the financial obligation is between you and this office, NOT between the insurance company and our office.

If you do not have dental insurance, you are expected to pay at the time of service unless prior arrangements have been made.

Any balances that remain unpaid after 90 days may be turned over to a Collection Attorney or Collection Agency unless an alternative payment plan has been established in writing. You will be held responsible for any fees incurred in the attempt to collect your balance.

We do offer no-interest payment plans through a third-party and we will be happy to give you more information on applying for this program.

If you have any questions at any time, please don't hesitate to call our office or ask our staff.

CONSENT FOR TREATMENT

1. I hereby authorize doctors or designated staff of Cosmetic Dentistry of Baton Rouge, LLC to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetic, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service regardless of insurance coverage unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account as well as any cost or fees related to the collection of this balance. I also agree that I will be held responsible to pay these mentioned amounts. If required, I also understand a check of my credit history may be made.
5. I grant right and permission to copyright, use, and publish photographic portraits or pictures of me in relation to dental treatment.

I have read and understood all of the above information.

Patient's signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____