ATTENTION PATIENTS

You Are Responsible For Knowing Your Dental Insurance Benefits

Dental plans differ significantly. Each patient should know and understand his or her individual benefit package. Please contact your insurance company at the telephone number on your insurance card if you have questions regarding your coverage.

Patients with dental insurance are responsible for paying any co-payment, deductible, or fees for non-covered services at the time the services are rendered. We will be happy to give you an estimated treatment plan, however this is *only an estimate* **and the patient is ultimately responsible for any payment not covered by insurance**.

To help you get the most from your dental plan, we encourage you to become familiar with your insurance plan before seeking care.

X_____ _____

Signature of patient or parent/guardian if minor Date

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental Care to third party payors and/or other health practitioners.

I authorize and hereby request insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s).

X_____ _____

Signature of patient or parent/guardian if minor Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

***CASH *PERSONAL CHECK *CREDITCARD *VISA * MASTERCARD *CARE CREDIT**

REGARDING MISSED AND CANCELLED APPOINTMENTS

At Unique Dental of Framingham, we strive to deliver our Best services at the most convenient times for our patients. It is for this reason we offer LATE EVENING **hours. This is why we will impose a** $50 "MISSED APPOINTMENT" fee PER HOUR **on appointments not cancelled and/or rescheduled within a timely manner. We ask that you kindly provide us with at least a** 24-HOUR NOTICE OF CANCELLATION**.**

X_____ _____

Signature of patient or parent/guardian if minor Date