## Financial and Insurance Information:

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from you for the costs incurred for your care and financial responsibility on the part of you must be determined before treatment.
All emergency dental services performed without previous financial arrangements, must be paid at the time the services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that you are personally responsible for payment of all dental services. Insurance is great, but if your insurance company chooses to be troublesome for all of us, we will expect **you** to handle any complications for services performed. We work for you, not your insurance company.

**Our dental office cannot render services on the assumption that our charges will be paid by an insurance company.**

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts retroactive from 60 days, unless previously written financial arrangements are satisfied. Other fees will apply if collection policies go into effect. ($13.50/mo stmt fee + $95 admin/collection fees.)

## Authorization and Release:

Consent for treatment:
I certify that I have read and understand all information regarding finance and medical history to the best of my knowledge. I understand the providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that if I have any further question, concerns, constructive criticism or complaints, it is my responsibility to contact Cold Springs Dental.

_____Patient\guardian signature _____Date

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**BELOW IS FOR OFFICE USE ONLY**

Medical History Review & Update:

_____

_____Date & Signature

_____

_____Date & Signature

_____

_____Date & Signature