Alexander City Dental Care
PLLC

Consent for Treatment

I hereby authorize a designated staff member of Alexander City Dental Care, PLLC, to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize to perform all recommended treatment that he and I have mutually agreed on, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics and other medication as deemed necessary for my comfort during my dental treatment. I understand that I may ask for a copy of any possible complications due to the use of these medications.

_____ **By initialing, I acknowledge that I have read the above statement and agree to its contents**

Financial and Cancellation Policy

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that if I carry dental insurance that Alexander City Dental Care, PLLC, cannot render services on the assumption that our charges will be paid by my insurance. I fully understand that I am ultimately responsible for the full payment of my/dependents treatment regardless of whether my insurance carrier deems the treatment as a covered charge. I understand that Alexander City Dental Care, PLLC, will file any dental insurance on my behalf, as well as, assist in the collections from those dental insurance companies. I understand that my estimated patient balance for any dental services, including dental emergencies, performed without previous financial arrangements must be paid in full at the time of service. I understand that a service charge of 1.5% per month will be charged on all patient account balances exceeding 60 days, unless previously written financial arrangements are satisfied. I accept that the fee for services charged is a legal and lawful debt, and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary. In addition, I understand that Alexander City Dental Care, PLLC, respectfully requests that I cancel a scheduled appointment at least 48 hours in advance. If I have two or more scheduled appointments that I miss without said notice, I understand that I may be dismissed from the practice.

_____ **By initialing, I acknowledge that I have read the above statement and agree to its contents**

Consent to Contact

I agree, in order to service my account or to collect monies owed, Alexander City Dental Care, PLLC, and/or our agents may contact me by telephone at any telephone number that I have provided to use in association with my account, including wireless telephone numbers, which could result in charges to me. Alexander City Dental Care, PLLC, and/or our agents may also contact me by sending text messages or emails, using any email address that I have provided to use in association with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

_____ **By initialing, I acknowledge that I have read the above statement and agree to its contents**

Non-Preferred Insurance Acknowledgement

Alexander City Dental Care, PLLC, is a Preferred Provider (PPO) for BCBS of Alabama, Cigna, Southland, Humana and Delta Dental. I fully understand that if I carry other insurance, it may not pay Alexander City Dental Care, PLLC, as much as it would pay another dentist in network on my plan. I agree to pay any and all balances on my account that are not covered by my insurance carrier. Alexander City Dental Care, PLLC, will not adjust any charges to comply with non-preferred insurance coverage. I acknowledge and fully understand the difference between a preferred/in network (PPO) dentist and a non-preferred/out of network (NON-PPO) dentist. I enlist Alexander City Dental Care, PLLC, as my dental caregiver regardless of my insurance company's preference.

_____ **By initialing, I acknowledge that I have read the above statement and agree to its contents**

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Acknowledgement

I understand that I may inspect and/or ask for a copy of Alexander City Dental Care, PLLC's posted HIPAA policy. I understand that my protected health information may be disclosed or used for treatment, payment, or health care operations. I understand that at any time, the authorization can be revoked in writing. I understand, too, that written revocation will not be effective as to the disclosure of records whose release I have previously authorized.

_____ **By initialing, I acknowledge that I have read the above statement and agree to its contents**

Patient's Signature _____ **Date** _____

Parent/Responsible Party's Signature _____**Relationship**_____ **Date** _____