MANSON & CHI
DENTISTRY

# Office Policies

**Financial Policy Agreement**

- As a courtesy, we are happy to verify your benefits and bill your insurance. Information received is not a guarantee of benefits or payment from the insurance company, we use this information to estimate as closely as possible your insurance coverage.
- Payment is expected at the time when services are provided. If you have insurance, the estimated patient portion of the fee is due at the time of service. Any other payment arrangement must be made in advance of services.
- We allow extra time for the insurance company to pay their estimated portion. If your insurance company has not fully paid a claim after a reasonable period of time (usually 30 days), you will be required to pay the remaining portion.
- I understand that any costs incurred during treatment are my responsibility. I realize that insurance may help pay part of my treatment and that the estimates quoted to me are only estimates. I will be responsible for any fees unpaid by the insurance company. I understand that there may be monthly interest (1.5%) applied to the balance and any additional costs of collection will be applied to the balance.

**Cancellation Policy Agreement**

- Our office does require 2 business days notice to change or cancel a reserved appointment. I acknowledge that I may be charged a $75 per hour fee if I fail to give at least 2 business days notice.

**Consent for treatment**

- I give consent for dental treatment by the doctor and staff.
- I understand that with each procedure there are particular risks and benefits. Possible risks for even routine treatment (such as fillings, crowns, root canals, and extractions) can be sensitive teeth, infection, paresthesia, traumatized pulp (nerve). Additional procedures may be required to treat further complication.
- The practice of dentistry is not an exact science, although we strive to give the best care possible, guarantees cannot be made concerning the results of treatment.
- I consent to the use of local anesthetics, antibiotics, nitrous oxide (laughing gas), analgesics (pain medications) and x-rays as needed to complete treatment.
- I understand that I may ask questions at any time regarding the risks, benefits and alternatives for any recommended treatment.

**Patient Name: _____ Date of Birth: _____**

_____ _____ _____

**Signature of patient, parent, or guardian** **Date** **Relationship to patient**