**Office Policies**

1.) **GENERAL TREATMENT CONSENT**

Direct Authorization for general treatment (Preventative, Restorative, Prophylaxis and X-rays) by Norwood Dental Cosmetics. I authorize Norwood Dental Cosmetics for myself /parent/guardian or behalf of the Minor Patient. \_\_\_\_\_\_\_\_\_\_\_ Initial

2.) **FINANCIAL AGREEMENT**

Payment is due at the time of service. As a courtesy to you, we will submit all charges to your insurance company. Insurance is designed to cover a portion of our fees only; your estimated co-pay will be collected at each appointment. I authorize my insurance company to make direct payment to Norwood Dental Cosmetics. In addition, I acknowledge that I have been informed of an estimated out of pocket expense and will be given opportunity to ask questions about my insurance coverage.

\_\_\_\_\_\_\_\_\_\_Initial

3.) **INSURANCE NETWORK**

I have been informed by Norwood Dental Cosmetics if they are contracted with my health care plan. I understand that if Norwood Dental Cosmetics is contracted with my plan, I am responsible of my co-payment as determined by my insurance. However, if Norwood Dental Cosmetics is NOT contracted or is out-of-network with my plan, I am responsible of all unpaid balances for services rendered \_\_\_\_\_\_\_\_\_\_Initial

* I have been informed Norwood Dental Cosmetics is in-network with my healthcare plan, OR
* I have been informed Norwood Dental Cosmetics is out-of-network with my healthcare plan

4.) **CANCELLATION AND FAILURE TO KEEP APPOINTMENT**

We understand that circumstances do arise that can keep you from your scheduled appointment. We require a 48-hour notice to change/cancel any appointment, as a result of this policy the following charges may apply. General /Hygiene $60.00. Specialist 5 days notice $110.00 \_\_\_\_\_­­­\_\_\_\_Initial

5.) **APPOINTMENT REMINDER CARDS**

**COURTESY CONFIRMATION CALLS /TEXTING/ E-MAIL**

I give Norwood Dental Cosmetics permission to send a reminder post card by U.S. postal service, via internet / telecommunication. \_\_\_\_\_\_\_\_\_\_Initial

6.) **COLLECTIONS**

Failure to pay your balance within 90 days; your account will be sent to a collection agency. There will be a $50.00 charge to process the collections account and a 20% collection cost added. \_\_\_\_\_\_\_\_Initial

By signing below, I understand and agree to the above listed General Consent for Treatment and Office Policies, for treatment and services rendered.

**Patient/Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**