Holliston Dental Associates

General Treatment Consent & Office Policies

1.) GENERAL TREATMENT CONSENT

Direct Authorization for general treatment (Preventative, Restorative, Prophylaxis and X-rays by Holliston Dental Associates. I authorize Holliston Dental Associates for myself /parent/guardian on 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 Holliston Dental Associates. _____Initial

3.) INSURANCE NETWORK

I have been informed by Holliston Dental if they are contracted with my health care plan. I understand that if Holliston Dental is contracted with my plan, I am responsible for my co-payment as determined by my insurance. However, if Holliston Dental 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 Holliston Dental is **in-network** with my healthcare plan, OR
- ☐ I have been informed Holliston Dental 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 72 hour notice to change/cancel any appointment, as a result of this policy the following charges may apply. General / Hygiene $60.00. _____Initial

5.) APPOINTMENT REMINDER CARDS / CONFIRMATION CALL /TEXTING/ E-MAIL

I GIVE Holliston Dental Associates permission to send a reminder postcard by U.S. post office, 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_____