

Lighthouse Dental Conditions of Treatment and Payment

Financial responsibility for each patient must be determined prior to treatment. Payment is expected at the time of service. We accept cash, checks, credit cards, and debit cards. We also offer outsourced interest-free financing (Citihealth or CareCredit) for those who qualify. Applications are available upon request and must be completed before treatment is begun. For those who have dental insurance, deductible and co-pays are also expected at the time of service.

Initials _____

As a courtesy, Lighthouse Dental provides billing services to our patients who carry dental insurance. This office will prepare and submit insurance forms. However, we cannot render this service on the assumption that our charges will be paid by an insurance company. Insurance will not usually cover 100% of services and you may expect a co-pay. **The patient, parent/guardian, or policyholder, is responsible to see that their insurance carrier has properly paid for their claim and is financially responsible for any service not covered by insurance** (after 90 days any unpaid insurance becomes due in full). We request that in the event that there is a change in insurance coverage, Lighthouse Dental be notified immediately so that we may update our records.

Initials _____

Your dental appointments are scheduled carefully and missed appointments add to the cost when staff and facilities are not utilized. We therefore request 48 hours if you are unable to keep your scheduled appointment. We also call 2 days in advance to confirm appointments. Consistent "no-shows," without notification, may result in a service charge. Also, a service charge of 1.5% per month (18% per annum) will be assessed on the unpaid balance on all accounts exceeding 30 days. A \$25 fee will be added to your account for all returned checks. In the event that an account balance becomes 90 days past due, final notification for payment in full will be sent to the responsible party. If no response is received within 10 days from the date of the letter, the account will be turned over to a collection agency and the patient will be released from dental care at our facility.

Initials _____

Estimated charges for treatment and payment policies are subject to change. The fee estimate listed for dental care can only be extended unless a new fee schedule is issued from an insurance company or Lighthouse Dental.

Consent for Services and Assignment of Benefits

I have read the above acknowledgement and give Lighthouse Dental consent to render dental services. I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance company to be paid directly to Lighthouse Dental. I also authorize Lighthouse Dental to release to my insurance company any and all information necessary for the processing of insurance claims. This would include, but is not limited to, the release of information to any third party that may be responsible for payment of all, or part, of any charges incurred on my behalf. I give permission to Lighthouse Dental, or assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above authorizations and conditions of treatment and payment and agree to their content.

Patient: _____ Date: _____
(Signature)

Parent/Guardian (if minor): _____ Date: _____
(Signature)

Relationship to Patient: _____