



To Our Valued Patients:

Today in the world of rising prices, we are trying to keep our fee increases to a minimum by implementing clear and exact payment policies.

- In order to keep billing to a minimum, **we ask that payment for services be made at the time treatment is rendered.** We accept the following payment types: cash, check, or credit cards.
- We do not offer in-house financing, however, arrangements have been made with **CareCredit** and **Capital One** to provide affordable **payment plans** with quick, easy, over the phone applications, and with plans starting at 0% interest. Applications are available at the front desk or you may apply online at **CareCredit.com** or **Capitalonehealthcarefinance.com.**

Patients with insurance: As a courtesy to our patients, we will file your insurance claims for you. WE MUST EMPHASIZE, however that as dental care providers, our relationship is with you, the patient, not the insurance company. Any problems that arise concerning your policy or coverage should be directed toward your insurance company.

You are responsible for paying your estimated co-pay at the time of treatment. You will also be responsible for any balance remaining after your insurance company has paid. In case of default of payment, I promise to pay any legal fees and interest incurred to cover any collection costs.

BROKEN APPOINTMENTS

Dr. Hansen and his staff are happy to provide your dental care services, however time is valuable to us and to you. It is important that you keep your appointed time with us so we can better meet your dental needs.

If you fail to notify this office of a cancellation less than 24 hours prior to your scheduled visit, you will be charged \$75.00 for your missed appointment.

I have read and understand the above policies and agree to abide by the policies of this office.

Signature

Date

CONSENT TO PROCEED

I authorize Dr. Jeff Hansen and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and or temporary or rarely permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerate (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial or serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)