Abbadent
FAMILY & COSMETIC
DENTISTRY

3430 Dodge Street
Inn Plaza
Dubuque, IA 52003
563.556.8388

Acknowledgement & Consent

Health History

I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the health questionnaire fully and accurately to the best of my ability.

Release of information

I understand that the dentist may need to collaborate with other healthcare providers and/or third-party payors in order to provide the best standard of care for me and my dependent(s). I authorize the dentist to release any necessary information regarding me or my dependent(s) that is relevant to my/their treatment to these providers and/or third-party payors during the period of dental care at Abbadent.

I authorize Abbadent Dental dentists and staff to discuss my treatment with:

_____ Relationship to patient:_____

Financial policies

I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, but they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not Abbadent Dental's responsibility. I authorize my dental insurance company to make payments directly to Abbadent Dental. I understand that I must forward any payments made to me within two weeks for services provided by Abbadent Dental.

I understand that I am expected to pay what is due from me or my dependent(s) treatment on the day of service. I understand that in the event of children with divorced or separated parents that the authorizing parent is expected to make payment at time of service (and will be billed for any unpaid balance), regardless of any documentation stating shared treatment costs. I understand it is Abbadent Dental's policy not to get involved in such matters and it is the authorizing parent's job to seek reimbursement from the other parent.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependent(s). I agree to be responsible for all charges on my account which have been applied in accordance with established office policy. I understand that I may be assessed an additional booking fee for any unpaid balances. I understand that if my account is not paid as agreed upon, the account may be transferred to an outside collection agency. Should legal action be taken to collect on my account, I promise to pay any applied interest, collection, court and attorney fees incurred.

I understand that my account will be charged a $30.00 fee for any returned checks and I will then pay the amount in cash including any additional fees.

Rescheduling & cancellation policy

When Abbadent Dental reserves time in the schedule for me or my dependent(s), I agree to keep the scheduled appointment time. Should something come up where I am unable to make it to my scheduled appointment, I will give at least 24 hour notice to allow Abbadent Dental the time needed to fill the empty appointment with a different patient.

_____ _____

Print patient name *Signature of patient (or parent/guardian if minor)* *Date*

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Relationship to patient