DAVID C. ADAMS, D.D.S., M.S., AND ASSOCIATES

SPECIALISTS IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALISTS IN PEDIATRIC DENTISTRY

PAYMENT POLICY & INFORMED CONSENT

We appreciate you choosing David C. Adams, D.D.S., M.S. for you or your child's dental care. At the office of Dr. David C. Adams, we value our relationship with your family and would like to offer the following as our payment policy.

Please initial each box as you read along the policies.

☐ If you have dental insurance, we will be happy to do everything we can to make sure you receive the maximum benefits available under your policy. However, please realize that the insurance relationship is between you, the insured, and your insurance company. If we do not receive payment from your insurance company within six weeks after submission of claim, you will be responsible to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed. *Please understand that we can only provide an **ESTIMATE** of how much your insurance might pay towards any treatment. A pre-authorization can be done by **REQUEST**, but will delay the treatment by approximately SIX (6) weeks.*

☐ For your convenience, we accept cash, Visa, MasterCard, Discover, and personal checks. There will be a $35.00 service charge for any returned check.

☐ If I decide to make payments using your accounting office for interest free payments, I hereby authorize OrthoBanc, LLC on behalf of David C. Adams, D.D.S., M.S. to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

INFORMED CONSENT

I authorize my insurance company to pay David C. Adams, D.D.S., M.S. all insurance benefits otherwise payable to me for services rendered. **I authorize** the use of this signature on all insurance submissions. **I authorize** David C. Adams, D.D.S., M.S. to release health information identifying my child under the following terms and conditions:

1) Patient information related to dental treatment and personal information if responsible party and policy holder required by my insurance company to get insurance claims processed and paid.

2) Dental insurance company for billing my insurance claims. Any other Medical or Dental professionals for Referral purposes to continue dental healthcare and ongoing treatment.

I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance and that all payments are due when services are rendered.

I understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of David C. Adams, D.D.S., M.S.

I have read and understand the payment policy at David C. Adams, D.D.S., M.S. .

Name of Patient: ______________________________

Name of Responsible Party: ______________________________

Responsible Party Signature: ______________________________ Date: ______________

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MEMBER OF THE AMERICAN ASSOCIATION OF ORTHODONTISTS AND CALIFORNIA STATE SOCIETY OF ORTHODONTISTS