PAYMENT POLICY & INFORMED CONSENT

We appreciate your choosing Dr. David C. Adams D.D.S., M.S. for you 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 line as you read along the policies.

________ If you have dental insurance, we will be happy to help you receive the maximum benefits available under your policy. Please realize that the 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 expected 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 which is normally not recommended in situations involving dental infections.

_________ Once the treatment plan and the estimated insurance benefits are reviewed with you, we require that you pay your portion in full when reserving your appointment time.

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

_________With your initials you authorize our office to electronically submit your check.

If you are interested in financing, please authorize by initialing below.
_________ 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 Dr. David C. Adams all insurance benefits otherwise payable to me for services rendered. **I authorize** the use of this signature on all insurance submissions. **I authorize** Dr. David C. Adams 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 Dr. David C. Adams D.D.S.,M.S.

I have read and understand the payment policy at Dr. 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