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Dr. Michael E. Love welcomes you to Restoration Dental.

We accept patients of all ages. You will have the opportunity to meet with our team and get to know Dr. Love. We are committed to educating you about your dental needs and will answer any questions you may have concerning your treatment. Our goal is to provide you with the highest level of dental care available today. Thank you for your confidence in our dental office and we look forward to meeting you.

PAYMENTS

We want you to be aware of & comfortable with your estimated financial responsibility prior to patient care. If at any time you have any questions about treatment or your financial responsibility, please notify a team member promptly, as we value open and honest financial relationships with all our valued patients.

Our office accepts the following payment types:

Cash/Check
American Express
Visa/Master Card
Discover Card
Care Credit Patient Financing

There will be a non-refundable **service fee of 4%** assessed for the use of all Debit/Credit card transactions.

INSURANCE & BILLING

- We can help you maximize your benefits. We recommend that you contact our office prior to your appointment to provide us with insurance information for verification of benefits. We accept most major dental insurance and will file most claims for you as a courtesy. We will provide you with an explanation of your dental benefits and financial responsibilities up front, and work with you to ensure financing if needed.
- It is our goal at Restoration Dental to provide you a clear understanding of your financial responsibility 1-2 weeks prior to your appointment date. We respect your finances.
- We have a cancelation policy and do charge a fee dependent on length of scheduled appointment for no-shows. We respect your time and hope you understand.
- We encourage the use of cash or checks for payment.
- We do accept all major credit cards. issues.
- All co-payments & deductibles are due at the time services are performed.

FINANCING OPTIONS

We provide multiple financing options to ensure you can receive the treatments you desire with a plan you can afford.

NSF FEES

We charge a $75.00 insufficient funds fee (NSF) for any returned check. We reserve the right to no longer accept checks as a form of payment from any account that has NSF history with us.

TREATMENT ESTIMATES

Our staff strives to give the closest estimate of treatment financial responsibility based on what information the insurance company provides to us. However, we can file a **Pretreatment** claim to your carrier to get a more exact figure. This process usually takes 2-4 weeks. Please feel free to request this service.

CANCELLATION POLICY

We want to provide the best possible dental care to you & your family. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is late cancelled or missed, that time cannot to be used to treat another patient. We ask that you give our office at least 24 hours' notice from the time of your appointment in the event that you need to reschedule or cancel your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment and a fee of $75.00 will be charged to you upon your late cancellation or not showing for your scheduled appointment; if you have insurance, your policy will not cover this expense and will be your direct responsibility. Additionally, if a patient is more than 15 minutes late, without prior notice for a scheduled appointment, we will consider this a missed appointment and the $75.00 cancellation fee will be charged and must be paid prior to rescheduling the missed appointment.

DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.
- We may need to use your personal information such as address, phone or email to remind you of your appointments, send treatment plans and other correspondence necessary for your dental and financial needs.

GENERAL CONSENT FOR TREATMENT

By signing this document you are agreeing that you read and understand the following:

I understand and authorize the doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I assume the right and responsibility to ask for any risks of treatment, alternative treatments, as well as the financial responsibility of the treatments.

I understand that the use of local anesthetics embody a certain risk. Complications and side effects are rare, but may include, among others not listed: Swelling, bruising or soreness at the injection site, numbness outside of the mouth, temporary rapid heartbeat, damages to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas, severe allergic and possible life threatening reactions necessitating emergency care.

I understand that if I have high blood pressure, uncontrolled thyroid problems, angina or have recently had a heart attack that I will inform my dentist verbally without fail as these conditions have caused complications for persons receiving local anesthesia. I assume the right and responsibility to ask for any alternative treatments, as well as the financial responsibility of the treatments.

I confirm that I am over the age of 18 years old. I understand that I am responsible for payment for the services provided for myself, or my dependents and it is payable at the time of services rendered or by the Financial Policies guidelines that I have read and understand. I authorize payment to be issued by my insurance carrier directly to this office. I also understand that any balance from the insurance company that is not resolved after 45 days is my responsibility.

ACKNOWLEDGMENT

I have read, had all my questions answered and understand/agree to the above communication methods, office financial policies and procedures and also to the general consent for treatment. I acknowledge that I received a copy of the Policies/Consent.

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