Dr. Costa & Dr. Waxman's Family Dentistry
255 Park Ave Suite 904 Worcester, MA 01609 Ph: (508) 791-1777

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Print Patient Name **Date**

General Consent, Financial and Appointment Obligations

Ensuring that our patients receive the highest quality of care is the goal of everyone at Dr. Costa & Waxman's. Our attention to detail, highest standards of infection control for everyone's safety, fine materials and quality clinical care are second to none.

We acknowledge that everyone's financial situation may be different therefore we offer a variety of payment options. For your convenience Dr. Costa & Dr. Waxman accepts most insurance plans. As a courtesy, we will give you insurance estimates as well as file your insurance claims for you. Please remember that we can only give you an **estimate** and it is your responsibility to check your benefits, eligibility, maximums and allowances of your specific insurance coverage before you begin any treatment. You will be responsible for ANY balances not covered by insurance for treatment rendered.

- **All** dental services and treatments are payable in full at the time of service. You will be asked to pay your estimated co-payment at the time of service. A billing charge, per statement, may be charged on any past due account balance past 30 days. This will help keep our costs down and ensure our ability to provide you with the best possible care for years to come.
- A **deposit** may be required to reserve longer appointments and will be applied to your account as credit towards any patient responsibility. This allows for us to give you our utmost attention in a timely manner.
- We truly understand our patients' schedules and daily lives are hectic, but in order to accommodate all of our patients needs, we kindly request a **48 hour notification** to cancel, change or re-schedule any appointments. If we are not personally available to take your call, messages may be left on our machine.
- Regarding **Diagnosis & Preventative Procedures:** I hereby Dr. Costa & Dr. Waxman's team members to perform all procedures deemed appropriate and necessary to aid in a thorough diagnosis of my dental needs or in attempt to prevent dental conditions. I understand this includes, but is not limited to X-ray films, patient photos, periodontal charting, diagnostic waxes or models of teeth, periodic dental exams and prophylaxis (cleaning),fluoride treatment and sealants. Upon diagnosis, I understand that I will have the opportunity for any questions regarding my treatment, risks, and/or complications to be answered by Dr. Costa & Dr. Waxman's Team.

Payment Methods / Options

- ALL payments are due at the time service unless PRIOR arrangements have been made. **Our office accepts:**

Checks, Cash, Discover, Visa, Master Card and Care Credit (external financing credit card)

Disclaimer: Although Dr. Costa & Dr. Waxman's office will process insurance claims (if applicable) on your behalf, a Dental Insurance policy is a contract between you and your Insurance carrier. Insurance coverage is only an estimate based on current, available benefits provided to this office by you and your insurance carrier. Our office relies solely on this information to estimate your liability for any treatment plans provided to you. Insurance companies reserve the right to pay, at their discretion, as of the date of service and is never a guarantee of payment. You, the Patient or guarantor are responsible for ALL balances due left by your insurance carrier for treatment rendered. All reasonable efforts will be made by our dental team to assist you to receive the maximum allowable benefit under you plan but, ultimately any account balance is solely your responsibility.
I further understand that any future proposed dental treatment and fees described to me are ESTIMATES based on current treatment plan(s) and may change. I understand that I will be given the opportunity to ask questions prior to my treatment and that there are occasions where the diagnosis or recommended treatment plan may change resulting in changes to the expected cost of such treatment.
I understand that by signing this agreement does not obligate me to any treatment not rendered.

____ **Date:** ____________
Patient, Guarantor or Responsible Party Signature