ERICKSEN DENTAL

ACKNOWLEDGEMENT

The previously stated information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that may have made in the completion of the form.

Signature _____ Date _____

INSURANCE ASSIGNMENT AND RELEASE

I the undersigned, have insurance with_____and assign directly to Dr. David Ericksen all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature _____ Date _____

MINOR/CHILD CONSENT

I, being the parent or guardian of_____do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature _____ Date _____

FINANCIAL POLICY

Payment is expected at time of treatment. We will gladly bill insurance as a courtesy; however, most insurance companies do not provide 100% of your payment. You are responsible for any charges not covered by your insurance. We do not extent payments unless prior arrangements have been made by our office manager. Finance charges of 1.5% will be added to any account over 60 days. In the event your account is turned over to an outside collection agency for non-payment or other delinquency, you will be responsible for payment of any collection cost and /or attorney fees, in addition to the balance owed.

Signature _____ Date _____

APPOINTMENT POLICY

Failed appointments are a significant contributor to rising healthcare cost. We require 24-hour notice for any appointment that you are unable to keep. A $50 fee will be charged to your account if you miss or cancel without the required 24 hours

Signature _____ Date _____