James B. Courrier, DDS, PLLC

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PATIENT ACKNOWLEDGMENT AND CONSENT FOR SERVICES

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

CONSENT FOR TREATMENT

By signing below, I consent to treatment and authorize Dr. James Courrier and/or Dr. Gina Boggeri to perform those procedures deemed necessary or advisable to improve and/or maintain my dental health, or that of the individual for which I am the authorized representative.

I understand that my oral health is my responsibility, and agree not to hold Dr. Courrier and/or Dr. Boggeri responsible for negative consequences due to my neglect or failure to follow recommendations. All treatment options entail some risks, and it is my responsibility to ask questions as necessary to acquire sufficient understanding of planned treatment. This office will exercise the utmost diligence to provide the best care available and and I voluntarily assume any and all risks, including the risk of substantial and serious harm.

FINANCIAL POLICY

Payment for services, including deductibles and co-payments, are due at the time of the service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment.

The office accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

Checks that are returned to our office from your financial institution are subject to a $50 returned check fee. This fee covers the processing fees that are charged to our office. A finance charge of 1.5% per month may be charged for any account which is not current or paid in full within 60 days from the date services were provided. I understand that if my account remains unpaid, it may be transferred to a collections agency.

ASSIGNMENT OF BENEFITS (AOB)

I understand that services rendered to me are my financial responsibility and that the provider will bill my insurance company as a courtesy. I hereby authorize and direct my insurance company to pay my benefits directly to James B. Courrier, DDS, PLLC. I understand that I will be fully responsible for any outstanding balance on my account. Should my insurance company send payment directly to me, I will promptly forward payment to James B. Courrier, DDS, PLLC or I will be billed directly. I understand I am ultimately responsible for payment of my account.

CANCELLATIONS OR RESCHEDULING POLICY

If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a $75 fee may be charged for every appointment cancelled. Appointments are scheduled to allow for enough time to provide the best service for you. Patients who arrive late for their appointments may have to be rescheduled.

COMMUNICATIONS

The office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

By checking the following box(es), I consent to the following methods of communication (Please check all that apply): *

☐ Phone ☐ Text ☐ Email ☐ US Mail

My signature below indicates my understanding and acceptance of the consent for treatment, AOB and policies included above.
Patient or Authorized Representative's Signature:

Signature _____ **Date** _____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

Response Date: _____