TREATMENT CONSENT, ACCOUNT RESPONSIBILITY & FINANCIAL POLICY

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at time of visit. We accept VISA, MASTERCARD, Cash, Checks and Debit Cards. If you have dental insurance, we will be happy to file your claim. Deductibles and estimated co-pays are due on the day of service. The policy holder is responsible for any balance not paid by the insurance company. We encourage you to check with your insurance company regarding specific coverage and limitations. Please note that Bridge City Braces uses only Composite Resin fillings. Some insurance companies limit coverage on these fillings. For larger treatment plans, outside financing is available with lowor no interest. Accounts 90 days overdue are subject to collection and additional fees; agency fees and other charges may apply. There may be a charge for appointments broken or cancelled with less than 48 hours notice.

Parent: _____

Address: _____ Home/ Cell Phone: _____

Parent Social Security: _____

Parent: _____

Address: _____ Home/ Cell Phone: _____

Parent Social Security: _____

If you have dental insurance, please complete the following:

Primary Insurance Plan: _____ Phone: _____

Subscriber:_____ ID or Social Security #: _____

Group Number:_____ Date of Birth: _____

Employer Name: _____

Secondary Insurance Plan: _____ Phone: _____

Subscriber:_____ ID or Social Security #: _____

Group Number:_____ Date of Birth: _____

Employer Name: _____

Being the parent or guardian, I do voluntarily consent to the performance of examinations, diagnostic procedures (including x-rays), fluoride treatments, sealants, extractions and resin fillings, or stainless steel crowns for my child. I understand that this consent will remain in effect for as long as the patient remains an active patient with Bridge City Braces. I understand that I may obtain a notice of Privacy Practices upon request.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize assignment of my insurance benefits directly to the provider, and authorize the provider to release any information required to process insurance claims. I understand the above information and certify this form was completed to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I've provided.

_____ _____

Signature (Parent or Guardian) Date