OFFICE POLICIES AND FINANCIAL AGREEMENT

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO THE FOLLOWING STATEMENTS:

I understand that my treatment plan is only an estimate and that there may be changes to my treatment plan, any additional fees will be discussed, and I will be responsible for any additional payment(s). My treatment plan may also include discounts or packaged pricing.

If I choose to not complete my treatment, I am forfeiting any discounts or special pricing and any refund will reflect that change in pricing.

I understand that Amazing Dental Solutions files my insurance as a courtesy to me and are not obligated to do so. I also understand that while my insurance may cover my treatment as a benefit, they may upon review determine that my specific case may be denied in part or whole. My insurance may decide there is not a medical necessity for this course of treatment and an alternate benefit not equal to the cost of my treatment may be paid. I have had my treatment options explained to me and have decided to move forward with my treatment. **A pre- authorization does not guarantee that payment will be made for my treatment and that ultimately, I am responsible for the portion estimated to be paid by my insurance company should it not be covered by them.** I understand that regardless of any dental insurance coverage I may have, **I am responsible for any additional dental fees**. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. Any fees collected for exams, prescriptions, canceled appointments, collections, etc. are non-fundable.

By Signing, I understand that any refund due to the patient may take between 30 – 90 days to be completed depending on the amount of the treatment.

I hereby authorize the dental staff of Amazing Dental Solutions to proceed with and perform the dental treatments as explained to me. I understand that treatment plan pricing is only an estimate and subject to modification depending on unforeseen circumstances that may arise during the course of treatment.

Patient/Guardian Signature

Date