DRIFTWOOD DENTAL
A LASTING IMPRESSION

## FINANCIAL POLICY

**I**n the interest of good communication and our continued commitment to provide the highest quality of dental care available to all our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

**W**e are committed to supporting you in understanding your dental health and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options.

1. Cash, cheque, and interact.
2. Visa, MasterCard, American Express
3. Discuss financing options.

**W**e will, as a courtesy, process your insurance benefits to reimburse you, patients are required to pay for their treatment in full on the day of service. All questions regarding your insurance benefits must be addressed to your insurance carrier.

*-- Dr.'s Cleworth, Ray and McLay*

**Patient Name** *(please print)*: _____

**I** agree that I am fully responsible for the total payment of all procedures performed in this office for myself – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion not covered by insurance is due at time of service for all services rendered.

Signature of Patient *(Responsible Person)*:_____ Date: _____

## CONSENT FOR TREATMENT

**I** consent to all procedures necessary for my dental diagnosis and care. These may include but are not limited to: the use of x-rays, local anesthesia, medications and/or any other diagnostic/restorative procedures.

**I**, the undersigned, hereby authorize Driftwood Dental to perform the procedure(s) or course(s) of treatment.

**I** am aware of my right to waive treatment of any kind and I am aware of possible consequences of non-treatment.

**I** have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures.

**I** authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s). I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

**I** have read and understand the information contained within this form**.** ☐ *please check.*

Signature of Patient *(Responsible Person)*:_____ Date: _____