105 North Park Lane
Mishicot, WI 54228
Phone: (920) 755-2336

www.mishicotdental.com

Treatment Consent and Financial Guidelines

Consent:
I consent to the diagnostic procedures and treatment by the Dentist necessary for proper dental care. I consent to the Dentist's use of disclosure of my records to carry out treatment, to obtain payment, and for those activities and healthcare operations that are related to treatment or payment. I consent to the disclosures of my records to the persons who are involved with my care or payment for that care.

Financial Guidelines:

1. I understand that I am responsible for all fees incurred by myself and/or my dependents. If I have insurance I also understand that I am responsible for all fees incurred by myself and/or my dependents regardless of what my insurance allows as usual and customary.
2. If I have insurance, I understand that I am solely responsible for knowledge of my insurance benefits, including amount of deductible, annual maximum, prophy limitations, etc. It is my responsibility to provide you with current/correct dental insurance information. Please understand that it is impossible for us to know the exact benefits of your specific policy, for we deal with over 2000 different plans. We will submit your claims to insurance for you and provide this service at no charge.
3. I understand that Mishicot Dental SC is not a Medicare provider and does not accept Medicare supplements.
4. Estimated co-pays and deductibles are due at the time of service. **If you do not have insurance, payment for all services is due in full on the date of service**. We accept, check, cash, credit cards and Care Credit.
5. **I understand that there will be a charge for missed or changed appointments not made at least 24 hours in advance.**
6. In case of divorce, the person that brings the child into the office is responsible to make sure that all services are paid for. Any arrangements made through a divorce agreement are strictly between the parents and do not involve the clinic. In the case of payment delinquency, I understand that I will be responsible to pay for all services incurred.
7. A $25.00 service fee will be charged to your account if a non-sufficient funds check has been written.

I attest to the accuracy of the information on this page and agree to make payments in accordance to this policy.

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Signature Date