LOWRY DENTISTRY

210 Willow Street • Gastonia, NC 28054

Date _____

Thank you for choosing Lowry Dentistry as your Dental Care Provider. We welcome you and your family to our office and are committed to providing you with high quality dental care. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy and consent for services form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your treatment as much as possible.

Patient Information

Patient Name *(First)* *(Middle)* *(Last)*	DOB	Gender - Circle One M F
Preferred Name	Home Phone	Cell Phone
Address	Email Address	
City/State/Zip	SS#	Marital Status - Circle One S M D W
Emergency Contact	Relationship	Phone # (H) (C)

Guardian Name _____ Relationship to Patient _____

Address _____

Phone _____

Employer/Insurance Information

Employer Name _____ Work # _____

Name of Insurance Co. _____ Ins. Co. Phone # _____

Name of Insured _____

Name of Policy Holder _____ DOB _____ SS# _____

Preferred Pharmacy _____

Address _____

Phone _____

OVER ▶

Office and Financial Policy Consent Form

As a condition of your treatment by our office, arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. We accept :

CASH CHECKS VISA MASTERCARD AMERICAN EXPRESS DISCOVER CARE CREDIT .

DENTAL INSURANCE

- We are contracted providers for the following Insurance Companies : Delta Dental Premier Aetna
- We will always do our best to help you maximize your benefits.
- Your treatment plan is individually tailored and is not based on your dental insurance benefits or lack of benefits.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. **It is your responsibility to thoroughly understand the coverage and exceptions of your policy.** Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer. **It is your responsibility to inform us of any changes in your insurance coverage.**
- Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim. Please ask if you have any questions.
- As a courtesy to all our insured patients, we will file your dental insurance claim forms. You are responsible at the time of treatment for payment to us of any applicable deductible and co-insurance.
- For insurance companies whose benefit check is payable directly to the patient, payment for services is expected at the time of service.
- Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.
- Please note ALL PENDING INSURANCE CLAIMS must be paid in full before a refund may be made.

Cancellation Policy

We respectfully ask that you give us a minimum of **48 hours** notice to cancel or reschedule your reserved appointment. A broken appointment is defined as one for which the patient failed to show up or cancelled with less than **24 hours** notice.

_____ I understand that the doctor is not responsible for completion of treatment if I fail to make scheduled appointments.
Initial

_____ I understand and accept the financial and the dental insurance policies listed above, and have had all questions answered to my satisfaction.
Initial

_____ I agree to pay for all treatment in a timely fashion as described.
Initial

I _____ hereby authorize my insurance benefits to be paid directly to Lowry Dentistry. I authorize Lowry Dentistry to bill my insurance company using the information I have provided to this office, and I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I realize that I am responsible to pay for any deductible, co-insurance, and any noncovered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing.

Patient/Legal Guardian Signature _____ Date_____ Staff Initial _____

I voluntarily consent to treatment at this facility by its doctors and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

Patient/Legal Guardian Signature _____ Date_____