AGAPE DENTAL GROUP

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Financial Policy

Dear patient (or parent),

please read this policy carefully before your dental visit ---------

The services at AGAPE DENTAL GROUP both dental offices have been arranged for your benefit because we feel it is important to offer an option for dental care with greater benefits for less cost.

You will be required to pay for your dental treatment as it is completed until we can verify your dental coverage. After we verify your coverage, you will be required to pay the difference between our fees and the amount your insurance company will reimburse us for your care. ***We cannot know the exact amount your insurance company will pay, but we will give you an estimate of your coverage before any dental treatment.*** If you overpay because the insurance company pays more than our estimate, you will be reimbursed. If for any reason the insurance company denies payment for any procedure, you will be responsible for the full cost of care.

For more complicated dental procedures, insurance carriers often require us to provide information before initiating treatment. They may approve, ("pre-authorize"), or not pre-authorize the treatment. If the insurance company does not pre-authorize any treatment, and you elect to have it completed, you will be responsible for the cost. Any insurance pre-authorization does not mean your benefit will be fully guaranteed. You are still responsible for any balance from your final insurance statement.

The attached Arbitration Agreement is also requested from you to assist in jointly reducing the costs of conflict resolution. By signing the enclosed Agreement, you are not, in any manner, giving up your ability to recover for damages in the event you have a problem. ***Arbitration is a process of problem resolution that is as effective by generally less expensive for both parties***. If, for any reason, you are not completely satisfied with the services you receive from this office, please give us a call. We will work to resolve any problems you may have.

The undersigned certifies that he/she has read and understands the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

______________________	______________________	__________
Please Print Name	Signature of: Patient/Parent/Conservator	Date

Preliminary Treatment Informed Consent

I give permission to AGAPE DENTAL GROUP to perform the initial comprehensive, and/or emergency diagnostic procedures including the necessary use of X-rays, to clean my/or my child's teeth and to apply fluoride to them. I understand that no further treatment will be provided until I am given and consent to a plan of treatment which describes the dental/surgical procedures to be carried out. I give permission to my doctor to use any part of my/or my child's records, other than his/her name, and to make and use photographs, video and audio tapes for insurance claiming, clinical teaching and/or research use.

______________________	______________________	__________
Please Print Name	Signature of: Patient/Parent/Conservator	Date