HANOVER ENDODONTICS, LLC
51 MILL STREET SUITE #4
HANOVER, MA 02339

General Consent Form

ASSIGNMENTS OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Hanover Endodontics, LLC or the dentist individually for services rendered to me or my dependents by the dentist. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any coinsurance, co-pays or deductible due that Hanover Endodontics is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify hereby authorize Hanover Endodontics, LLC or the dentist individually to release any of my or my dependent's medical, dental or incidental non-public personal information that may be necessary for medical/dental evaluation, treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, E-MAIL, CALL OR TEXT:

I certify that I understand the privacy risks of the mail, e-mail, phone calls and text messaging. I hereby authorize Hanover Endodontics, LLC representative or dentist to mail, e-mail, call or text me with communications regarding by dental health, including but not limited to things such as appointment reminders, referral arrangements and follow up care. I understand that I have the right to rescind this authorization at any time by notifying Hanover Endodontics, LLC to that effect in writing.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by Hanover Endodontics, LLC or his or her designee.

Financial Policy

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the responsibility of the patient and due at the time of service. This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the difference. In the case that overpayment is made, all refunds will be processed back to the original form of payment, except cash payments will be refunded by check.

Dental benefits are contracts between the policy holder and the insurance company, not our office. We will make every effort to assist you with any benefit questions however, we suggest that you be aware of what benefits you have available. Ultimately, you are responsible for the balance.

Broken Appointment Policy

When you make an appointment, the time is reserved just for you. It is considered confirmed. We will call, text, or email you two days prior to your appointment as a courtesy reminder only. If for any reason, you miss or cancel an appointment without giving 48 hours' notice more than once in a 12-month period, you will be billed$50 for each appointment hour and your appointment will not be rescheduled, instead only same day appointments will be offered to you. Please call the office during regular business hours to reschedule an appointment. The appointment we have reserved for you is valuable and can be used for patients who are concerned about their oral health and are waiting to be seen. Without adequate notice this valuable time is simply lost.

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is rendered, your co-payment will be expected at that time. **If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for full fee. I also understand that if my account becomes delinquent I am responsible for an administrative fee of $150, not including any court or attorney fees.**

By signing below, you understand and accept the terms of our **Financial Policy.**

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Signature of Patient/Responsible Party Date