dentalfacultypractice
at The Ohio State University

INITIAL CONSENT FOR TREATMENT, INSURANCE RELEASE/ AUTHORIZATION/ASSIGNMENT AND FINANCIAL RESPONSIBILITY

Patient Name: _____ **Date of Birth:** _____
Last First Middle Initial MM / DD / YY

Please Read Each Paragraph and Initial

Initial Consent for Treatment

_____ I hereby give consent (permission) for the dentists and staff of the Dental Faculty Practice to initially treat me. This includes any procedure (s) as deemed necessary in the exercise of their professional judgment. I understand that no further treatment will be provided to me without consent to a formal treatment plan which describes the procedures deemed appropriate to complete my care.

Radiographs, Photographs & Models

_____ I hereby grant permission to the Dental Faculty Practice to perform routine diagnostic procedures including the necessary capture/use of radiographs (x-rays), photographs and models for the purpose of treatment planning, case documentation and insurance claims processing. I understand that reproduction of radiographs, photographs and/or models for purposes other than noted above require an additional consent/release for any publication.

Release of Patient Record for Teaching Purposes

_____ I hereby grant permission to the Dental Faculty Practice to use my Patient Medical Record (radiographs, photographs, models, progress notes, etc.) without publication of my name for the purpose of teaching and scientific publication. *Should this be something you do not desire, do not initial.*

Insurance Verification/Release/Authorization/Assignment

_____ I certify that the information pertaining to my active dental and/or medical insurance coverage is correct.

_____ I authorize the release of any dental/medical records or other information including the diagnosis and treatment rendered to me, as requested by my dental and/or medical insurance carrier. I am aware this may include information regarding HIV or AIDS, alcohol or drug abuse and psychiatric treatment.

_____ I request and assign benefit payment (s) from my insurance carrier (s) directly to the Dental Faculty Practice and to the practitioner who rendered my service.

Financial Responsibility

_____ I understand that payment is expected in full prior to the services being rendered for patients who do not have dental or medical insurance (if applicable) coverage.

_____ I understand that should I arrive on the day of my appointment with no means of payment, the Dental Faculty Practice reserves the right to reschedule my appointment.

_____ Missed or Broken appointments (if less than 24 hours notice may have a fee assessed at the provider's discretion and this fee is the patient's responsibility.

Patients who have verified dental (and/or medical, if applicable) insurance benefits

_____ I understand that the financial obligation for any services rendered/received is my responsibility and not the responsibility of the Dental Faculty Practice, my provider of service or my insurance carrier. I understand that the Dental Faculty Practice will make reasonable effort on my behalf to obtain all applicable benefits from my insurance carrier (s) but there is no promise or guarantee of payment/coverage. Any balance due after insurance processing and/or insurance payment received is my responsibility. ***Note** Account balance is due 60 days from the date of service whether payment has been received from your insurance carrier or not.*

_____ Co-payment, Deductible and Deposit (in some cases) is payable prior to the services being rendered. A predetermination of dental benefits will be submitted (time permitting) prior to initiation of treatment in order to obtain the estimated patient out-of-pocket expense.

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. (if applicable) and Flexible Spending benefit cards or checks are acceptable.
- Care Credit - For those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association approved commercial line of credit specifically designed for the payment of dental care. To learn more Care Credit, feel free to speak to the financial office.

****PLEASE NOTE****

Divorced Parents: ***The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.***

_____ **MEDICAID PATIENTS** I understand I must submit my current Medicaid identification card on the day service is rendered. I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

_____ **MEDICARE PATIENTS** I understand that Medicare rarely covers dental procedures and I am responsible for the full fee associated with such services. I understand that after Medicare processes my claim any balance due is my responsibility. I agree to pay this balance within 30 days.

FINANCIAL RESPONSIBILITY

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?

PATIENT IS RESPONSIBLE PARTY

RESPONSIBLE PARTY INFORMATION (Complete if patient is not responsible party)

NAME _____ RELATIONSHIP ☐ Spouse ☐ Parent ☐ Other

DATE OF BIRTH _____ SOCIAL SECURITY #_____

HOME PHONE_____ CELL PHONE _____

HOME ADDRESS _____

_____
City State Zip

EMPLOYER _____ PHONE _____

ALTERNATE CONTACT (CLOSEST RELATIVE WHO DOES NOT LIVE WITH YOU)

NAME _____ RELATIONSHIP _____ PHONE #_____

By signing below I verify that I have read, understand and accept the guidelines and terms stated within in the Dental Faculty Practice Initial Consent for Treatment, Insurance Release/Authorization/Assignment and Financial Responsibility form and that I am the financially responsible party for this patient account.

_____ _____ _____

Signature of Responsible Party Print Name Date