KIEU M. LE, D.D.S., PLLC

FINANCIAL CONSENT FOR SERVICES

AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, SERVICES RENDERED TO YOU OR ANY COVERED FAMILY MEMBERS MUST BE PAID AT TIME SERVICES ARE RENDERED OR ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COST INCURRED IN THEIR CARE AND FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT.

PATIENTS WHO ARE COVERED UNDER DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT AND THAT HE OR SHE IS PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES. WE ARE NOT CONSIDERED PARTICIPATING DENTISTS IN ANY DENTAL PLAN. THIS OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTIONS THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY. HOWEVER, WE WILL PREPARE AND SUBMIT, AT THE PATIENT'S REQUEST, ANY CLAIM FORMS OR ASSIST IN MAKING COLLECTIONS FROM INSURANCE COMPANIES AND WILL CREDIT ANY SUCH COLLECTIONS TO THE PATIENT'S ACCOUNT. PATIENT AGREES TO PRESENT EVIDENCE OF CURRENT INSURANCE COVERAGE BEFORE THIS OFFICE CAN SUBMIT CLAIMS TO THE INSURANCE COMPANY ON BEHALF OF THE PATIENT AND AGREES TO NOTIFY US OF ANY CHANGES TO INSURANCE COVERAGE.

I GRANT MY PERMISSION TO THIS OFFICE OR ASSIGNEE, FOR CONTACT VIA ANY AVAILABLE CONTACT INFORMATION, REGARDING MYSELF OR COVERED FAMILY MEMBERS TO CONFIRM APPOINTMENTS, TREATMENT OR ANY BILLING QUESTIONS WHICH MAY BE NEEDED BY THIS OFFICE.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____

NAME OF PATIENT

_____ DATE _____