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116 N. Halcyon Rd.
Arroyo Grande, Ca. 93420
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Financial/Appointment Consent Form

For _____ (patients name)
We welcome you to Dr Shauna Hayes Dental Practice. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review thoroughly and complete our office and financial policy and consent forms. We are happy to discuss your proposed treatment, financial options, and any other questions you may have. We strive to keep you informed and involved with your treatment and insurance as much as possible.

Dental Insurance
_____ (initials) I / We *DO NOT* have dental insurance
_____(initials) I / We *DO* have dental insurance (if so, please continue below)
If you do have dental insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patients responsibility to inform Dr Hayes's staff of the change at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Dr Hayes's Office. Any fees that are not paid in full by a patients insurance are the responsible parties responsibility.

Dr. Shauna Hayes office will provide you with an *ESTIMATE* of your out of pocket expense for any treatment planned by the Doctor. However please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse you/us according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date services are rendered. If difficulty arises with payment from your insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 60 days from the date of service becomes the immediate responsibility of the patient and/or the account holder.

Payment for services (copay/coinsurance) is due in full at the time services are provided.

I/We understand the above paragraph regarding dental insurance, and have had the opportunity to have any questions answered to the best of Dr Hayes's Staff's ability.

_____Signature of Responsible Party_____ Date