Millhopper Family Dentistry
3510 NW 43rd Street
Gainesville, Florida 32606
www.millhopperfamilydentistry.com

Office Agreement and Consent Form

1) We accept Cash, Check, Visa, MasterCard, Discover, American Express and CareCredit cards.

2) An appointment reservation deposit of $400 (regardless of insurance benefits) is required when scheduling an appointment for major services. This deposit is non-refundable (if the appointment is missed) at the discretion of Millhopper Family Dentistry.

3) Dental Insurance: We will be happy to submit an insurance claim for you as a courtesy. Most insurance claims automatically file electronically. It is your responsibility to inform us of any changes in your insurance carrier or policy. If your insurance company denies your claim, we expect payment of the full balance within 10 days of the notice you receive from your insurance company. Professional services are rendered to a person, not to the insurance company. **Our treatment is based on the dental need of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company.** We will help in any way possible to file your claim or handle any insurance queries you may have. It is your responsibility to be involved with your insurance company. **The patient is responsible to the doctor and the insurance company is responsible to the patient.**

4) Saturday Appointments: A credit card is required to schedule an appointment on a Saturday. We will keep the credit card on file and it will only be charged if the appointment is missed or cancelled/rescheduled within 48 hours, at the discretion of Millhopper Family Dentistry.

5) Returned Checks: There is a $35.00 handling fee for any returned check.

6) Missed Appointments: No Charge will be made for rescheduling an appointment provided a 48 hour notice has been given; otherwise a minimum charge of $25.00 per half hour of the missed appointment will be posted on the account. Please remember that this time has been reserved specifically for you.

7) **Attorney and/or Collection Fees**: If your account becomes delinquent and is submitted to a collection agency, you will be responsible for an additional 35% collection fee.

We are here to help no question is too small for you to ask. Please feel free to call when you have a question.
Thank you for your loyalty and for your referrals of your friends and family.

I authorize release of any information and/or x-rays relating to my dental treatment to the insurance company, attorney or collection agency in collecting the full cost of the services provided for myself and my family.

I agree to accept the standard fees of this office regardless of my insurance benefit agreement and I understand that there may be a difference in the insurance plan fee and the standard fee. I take responsibility for the entire fee charged. I understand that this office expects that I pay in full for the services as they are provided. If I do not hear from my insurance company within 60 days, I will contact them and inform Millhopper Family Dentistry of the situation.

I authorize release of any information and/or x-rays to dental offices where I have been referred.

I have received a copy of this office's Notice of Privacy Practices.

Consent:
The undersigned hereby authorizes Millhopper Family Dentistry to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the patient and further authorize and consent that the doctor choose and employ such assistance as deemed fit. I understand the use of anesthetic agents embodies a certain risk**.** The financial responsible party agrees to the terms on this Office Agreement and Consent Form.

_____ _____ _____
Name (Printed) Signature Date

_____ _____
Patient's Name (If you are not the patient) Relation to patient