CREEKSIDE DENTAL CARE #6100 – 403 MACKENZIE WAY SW AIRDRIE, AB T4B 3V7
P: 403-980-9900

Please initial by each box to indicate you have read these policies

☐ Due to the recent legislation, you are covered under the privacy act; your information through your insurance provider is confidential and will not be released to our office. Therefore, we urge you to become familiar with any dental benefits you may have. Ultimately if there is a problem with your insurance, it is your responsibility.

No Insurance or Non-Assignment Plans

☐ Full payment is due at time of treatment.

Two Payment options are available - Please choose ONE only

Option 1 (Non-Assignment)

☐ All accounts are paid at the time of service. The cheque is mailed by your insurance company, made payable to the subscriber and you may receive it in as little as 3 days.

Option 2 (Assignment)

☐ In order for Creekside Dental Care to accept payment from your insurance, our office requires the following:

- Any portion not covered by insurance must be paid at time of service
- Valid Alberta Drivers Licence
- All accounts to be cleared within **45** days from treatment date otherwise a **15%** interest charge will incur

* Alberta Driver's Licence _____

To make my checkout as efficient as possible I authorize Creekside Dental Care to put through my outstanding balance automatically on my:

*Visa/MasterCard _____expiry_____

☐ The insurance claim will be sent electronically. If Insurance does not provide the exact patient portion, our office will estimate your portion for the visit. Should the charge be over $200.00, our office will try to contact you prior to putting the charge through, however we are not calling for authorization but rather to make you aware of the charge.

In the rare case that we have not received the insurance payment within 31 days, we will then contact yourself so that you may contact your insurance company to enquire about the claim. If within 45 days of your treatment our office has still not been paid, we will then inform you that your credit card will be charged the total amount owing. All collection costs will be paid for by the patient.

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Please initial by each of the following statements

☐ If you require pre-authorization it is the responsibility of the patient to request our office to complete one on your behalf. Our office will only complete one on your behalf once the corresponding appointment is booked due to the amount of time and work that goes into each pre-authorization. Once the pre-authorization has been assessed by your insurance, it will then be forwarded to your policy holder. Our office will not receive a copy unless it is provided to us by the patient. Please either email, fax or drop off a copy to our office so that we may assess the accuracy of the pre-authorization. At that time, we would be more than happy to complete a breakdown of your coverage so that you are aware of your estimated payment from insurance.

☐ We do our best to respect our patient's time and in turn ask for the same courtesy. Therefore, our office requires 48 hours notice to change a scheduled appointment. If we are not provided such notice or an appointment is missed a **$50.00 and up** fee will be charged. This fee must be paid prior to any further appointments.

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependants (if any).

Thank you for choosing Creekside Dental Care, we look forward to taking care of your dental health.

If you have any questions regarding this agreement, please do not hesitate to bring it to our attention.

Signature: _____ **Date:** ☐

(Signature of patient, parent, or guardian)