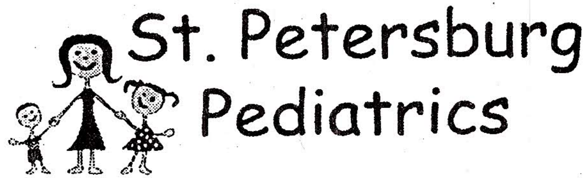

CONSENT TO TREAT FORM

I, ______________________________ GIVE PERMISSION FOR THE FOLLOWING

PERSON(S) TO BRING MY CHILD ____,

DOB _________________, TO THE DOCTOR'S OFFICE FOR TREATMENT.

NAME:	RELATION:
______________________________	_____________________
______________________________	_____________________
______________________________	_____________________
______________________________	_____________________
______________________________	_____________________
______________________________	_____________________

PARENT SIGNATURE: ____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the excellent treatment of all of our patients, and we will always do our best to provide excellent care. as in most medical practices, medical fee reimbursements continue to decrease while our costs continue to increase. We have implemented this Patient Financial Policy to help control costs so that we can always provide high-quality medical care.

PRIVATE INSURANCE AND SELF PAY

Payment at the time of service is required for office visits, unless other arrangements are made in advance.

We are happy to assist you in billing your insurance company for all procedures and requesting the insurance company to remit the payments directly to our office. Of course, you are responsible for the annual deductible and any co-pay insurance requirements at the time of treatment. As well as any difference between the amount of our fee and the amount received from your insurance company (indemnity insurance as well as coverage under a letter of protection).

You are also responsible for calling your insurance company to verify that we are health care providers for your insurance plan before making an appointment with our practice (this is vital to the reimbursement rate).

HMO, PPO

If you are covered by an HMO or PPO and we are not the primary care physician your insurance company may not pay for the treatment, and then of course, you will then be responsible for payment. Make sure, before making an appointment with our office, that we are the primary care physician of your child/children.

MEDICAID

We participate with medicaid and fully cooperate with all of the rules and regulations. However, you are responsible for payment, if the medicaid number is not eligible or not on file.

I have read the Patient Financial Policy and agree to abide by its terms, as well as authorize my insurance company to forward the Explanation of Benefits and related payments directly to the physician's office.

X______________________________ Date______________

Signature of Patient

X______________________________ Date______________

Signature of Parent/Guardian