Prairie Lakes Family Dentistry, LLC

I) INFORMED DENTAL CONSENT

It is very important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures and all of your questions have been answered.

Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are many variables involved, some predictable and others not. Complications in dentistry are very low, but they do exist. Even minor procedures like a simple 'filling' can lead to major complications that can't be foreseen. For example, a 'Novocaine' or local anesthetic injection could lead to an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating treatments should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscesses, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read and understand Informed Dental Consent and consent to dental treatments.

Initials_____ Date_____

II) FINANCIAL POLICY

1. Patients WITH Insurance Coverage:

Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments to your account. We can request a pre-estimate of benefits from your insurance carrier if you request to do so. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles at the time of treatment. If your insurance company has not paid the claim in 45 days, the balance will be automatically transferred to you. In some cases, insurance carrier may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be

a portion that is your responsibility. All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due at the final delivery of appliance. The balance must be paid before final insertion. If you are having extensive treatment over a period of time, we request payments during the course of treatment. Our financial coordinator will assist you in arranging a payment schedule.

2. Patients WITHOUT Insurance Coverage:

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, Check, MasterCard, Visa, Discover, & American Express. We also arrange pre-payments and financing plans with Care Credit.

III) OFFICE POLICY CONCERNING SCHEDULING APPOINTMENTS

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. We expect at least a 24 hour notice. For appointments that are cancelled less than 24 hours will reflect a fee of $50.00.

Initials_____ DATE: _____

IV) BILLING POLICY

1. Checks returned unpaid from the bank are subject to $40 service fee.

2. Accounts delinquent more than 60 days from the date of billing are subject to a 2.5 % per month (30%annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

We welcome you to our office and want to provide you the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND PRAIRIE LAKES DENTISTRY LLC'S INFORMED DENTAL CONSENT, FINANCIAL POLICY, SCHEDULING POLICY AND BILLING POLICY.

Signature of Patient/Parent or Guardian (if minor)_____

DATE: _____