DUNES DENTAL SERVICES
DR. ALINA MUNTEAN

RELEASE FOR TREATMENT

PATIENT NAME: _____ DATE: _____

- I am electing to have the treatment performed with the understanding that my insurance company may or may not pay benefits, and that insurance coverage is an ***estimate*** only because my range of benefits depends solely on what level of benefit that has been purchased. (Alternative benefits, pre existing conditions, treatment exclusions, waiting periods, annual maximums and deductibles, etc... May apply), and that Dunes Dental Services has no relationship with my insurance company, only with me as a patient. Should questions arise concerning a claim filed by this office on my behalf, I understand this office will assist me in resolving the matter. Final resolution is my responsibility due to my relationship with the insurance company and any claims remaining unpaid by the insurance company for 45 days become my entire responsibility and will be due immediately.

- I certify that I, and/or my dependent(s), have insurance coverage and authorize payment of the dental benefits otherwise payable to me directly to Dunes Dental Services, for services rendered. I understand that I am financially responsible for all charges regardless of insurance payment. I authorize the use of my signature on all insurance submission.

- I understand that, as a courtesy, Dune Dental Services will attempt to verify my insurance coverage from the information that I provide. I am required to pay in full, the ***estimated*** portion of any procedure or treatment that will not be covered by my insurance.

- I understand that the ***insurance estimate may differ*** from what my insurance carrier ultimately pays and I am responsible for any amounts not paid by my insurance for any reason.

- I understand if I fail to pay my account in a timely manner, Dune Dental Services will apply interest to each overdue account at the rate of 1.5% per month (18% annually) from the original due date. Accounts over 90 days will receive a final notice and further action will be taken and may be reported to credit rating bureaus or to a collection agency and/or take legal action against me for full payment including, but not limited to, all related reasonable attorney's fee, collection and/or court costs.

- I understand it is my responsibility to immediately notify Dunes Dental Services of any changes to my address, phone number, insurance coverage, health history, etc...

- I understand that Dunes Dental Services requires me to confirm my appointments, and that they will do their best to contact us with appointment reminders.

- I understand Dunes Dental Services has an office protocol that requires a **48-hour notice (excluding weekends) for any changes in scheduling**. I have several options to reassure Dunes Dental Services that I will be committed to my appointment. My option of an on-line account has been reviewed with me and I fully understand the following:

  PLEASE CIRCLE THE NUMBERED OPTIONS THAT YOU WOULD PREFER COMMUNICATIONS

  1) Email (1st email-2 weeks before appointment & 2nd email is 3 days before appointment)
  2) Automated Voice Calls (1 week before appointment, PLEASE LISTEN TO THE WHOLE MESSAGE AND FOLLOW PROMPTS TO "PRESS#1 TO REASSURE US YOU WILL BE HERE")
  3) Text (As a courtesy one day before your appointment)

  Failure to keep a confirmed appointment without 48-hour notice will result in a fee for the failed appointment, broken appointment fee will be based on the treatment to have been provided and the time reserved with the Dr. /Staff member. Minimum fee will be no less than $50.00.

- I understand and agree to the above terms and conditions.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Witness Date