Cleveland Center for Integrative Dentistry
Patient Agreement

We are committed to providing you with the best possible care. Toward this goal, we would like to explain your financial and scheduling agreement with our practice.

Payment: Payment is due at the time services are rendered. We accept the following forms of payment: Cash, Checks, Master Card, Visa, Discover, and American Express. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice when necessary. [Initial]_____

Dental Benefit Plans: Your dental benefit is a contract between you, or your employer, and the dental plan. Benefits and payments received are based on the terms of the contract negotiated. We are happy to help our patients with dental benefit plans to understand their coverage, but we cannot guarantee the accuracy of information received from the insurance company or any changes regarding that contract. [Initial]_____

We are not a contracted provider with your dental benefit plan. It is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. ***IF*** your plan allows reimbursement for services, our practice can file the claim with your plan and the plan's subscriber will be reimbursed directly from your insurance company. Though, for your convenience, we will file your initial claim for services, your insurance company will not communicate with us any further regarding your claim because we are not accepting assignment of benefits. You are responsible for following up on the claim and obtaining reimbursement, and will be responsible for payment-in-full to our practice before, or at the time of service. [Initial]_____

Scheduling appointments: We reserve time in our schedule for each patient procedure, so when a patient cancels an appointment, it impacts our availability to care for other patients. To maintain the utmost service for all of our patients, we do require 24-hour notice to cancel or reschedule an appointment. With less than 24-hour notice, a fee of $50.00 may be required. We do understand emergencies arise, and ask that you notify us as soon as possible. [Initial]_____

Authorizations:
I authorize the team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment discussions. (Initial) _____

I authorize the release of information necessary to process my dental benefit claim and I understand payment will be made directly to the insurance subscriber for services rendered to me (Initial) _____

Signature of responsible party: _____

Date: _____