CASTLE ROCK
MODERN DENTISTRY AND ORTHODONTICS

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Financial Arrangement

Service	Provider	Who the service was for	Date of Service	Amount
Dental (Teeth Whitening)	Dr. Van Nostrand DDS	Linda Smith	02/05/21	$250.00

$250.00

Payment Terms

Payment $ _____

Payment Date: _____

I have been informed of my choices/options and fees in regard to treatment alternatives, including my covered benefit(s), where applicable. I have chosen to go outside the covered benefit on my Insurance Plan and proceed with the accepted/planned treatment at the fees listed above. I understand that this treatment will be considered optional, alternate, not covered, and/or cosmetic by my Insurance Plan. I also understand the billing descriptions/codes required for claims submittal to my Insurance Plan may not adequately describe the treatment I have chosen. My Insurance Plan may catalog the treatment I have chosen based solely on the descriptions provided for use rather than the treatment actually provided. By choosing the accepted/planned treatment listed above, I understand that I have more out-pocket expense than if I were to go with my covered benefit under my Insurance Plan and agree to be fully responsible for any additional expense.	**Patient/Responsible Party Initials** **No Signature Available** **Initials**

I agree that I am financially responsible for all treatment started. I hereby assign the office to all my rights, title and interest to receive medical and/or dental benefits and/or insurance reimbursement from my insurance plan for any and all services rendered and the right to pursue all causes of action. In consideration of the health care services provided to me, I agree to pay all charges which are my responsibility under my insurance plan, or which are not covered by my insurance plan or any applicable health benefit, including, but not limited to, deductibles, copayments and non-covered services. I agree that my Insurance Plan coverage has been explained to me and I understand that all amounts listed above, including the estimated amount and my estimated out-of-pocket/patient expense, are only estimates. I agree to be fully responsible if my Insurance Plan does not pay these estimates for any reason and understand that this may increase my out-of-pocket expense. Any changes in any of the amounts due to Insurance Plan coverage will be my responsibility. I understand that the office's contracted fee with my Insurance Plan(s) may not be the same as the Estimated Fee set forth above. In the event my Insurance Plan(s) pays more than its estimated amount, I understand that this may not reduce my patient share. Once my Insurance Plan(s) adjudicate(s) my claim, if my patient share was overestimated, I will be refunded any excess by the office.
Any change in my treatment plan either by my choice or by necessity will change the fees quoted. I understand that whenever possible, I will be informed of any changes in advance. I have read, fully understand and authorize the treatment as presented to me today.

Patient/Responsible Party Signature:	**No Signature Available** **Signature**