SpokaneDental

Assignment and Release

I, _____(full name), the undersigned, have insurance with _____(insurance provider), and assign directly to Spokane Dental all benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my submissions whether manual or electronic.

Date:_____ Signature :_____

Financial Policy Agreement

I hereby agree to be responsible for the costs of care provided by Dr. Shoquist and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, maximums and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment. **I understand missed appointments will incur a fee of seventy-five ($75) dollars assessed to my account.** This fee is necessary to cover the cost of the office overhead during the time set aside specifically for me or for my dependent(s).

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. Because we do not double book our schedule and reserve your appointment time exclusively for you, we ask that you make every effort to be on-time and keep your scheduled appointment.

I understand that for any treatment, payment is due at time of service. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date:_____ Signature :_____

Minor/ Child Consent

I, being a parent or guardian of _____(name of minor), do hereby request and authorize Dr. Shoquist and his team perform necessary dental services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date:_____ Signature :_____