AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Leonard Pizzolatto. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed and implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Leonard Pizzolatto to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Leonard Pizzolatto

Photography Release

I authorize Dr. Leonard Pizzolatto to take photographs of me to help me better understand my current dental condition and possible treatment options.

FINANCIAL POLICY

We would like our patients to be informed of our financial policy. We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our financial policy.

Payment is due in full at the time service is rendered for self pay patients. Deductible and estimated out of pocket expense is due at time of service for insured patients. I understand that after insurance pays I am responsible for any outstanding balance that is not covered by my insurance policy. We accept cash, personal checks, Visa, MasterCard, American Express, Discover and financing available through Care Credit based upon approval. Returned checks are subject to a NSF fee of $40.00 per check. If the check is not settled with the financial coordinator, it may be turned over to the Terrebonne Parish District Attorney's office. In the event account is not paid in full within 30 days and contact is either denied or not accepted by the patient or patient's guardian, accounts will be turned over to our collection Attorney. After 30 days, I, the undersigned, agree to pay all cost of collection fees and agree to pay interest at the rate of 1.5% per month on the unpaid balance from due date of account until paid in full and hereby waive all rights of exemption under the constitution and laws of the State of Louisiana.

If you have dental insurance, you must bring in your dental insurance card for proof of insurance and we will verify benefits in order to submit your insurance claims forms for you. However, you must realize:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. We cannot render services on the assumption that the charges will be paid for by the insurance company. All charges are your responsibility from the date the services are rendered.
3. Our fees are generally considered to fall within the acceptable range (U.C.R.) by most insurance companies, and therefore should be covered up to the maximum allowance determined by each carrier.
4. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. Remember: please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

We must emphasize that as dental care providers, our relationship is with you, the patient, and not your insurance company. While filing your insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment to your account. If such situations do arise, we encourage you to contact our financial coordinator promptly for assistant in the management of your account.

My signature acknowledges that:

1. I understand and will comply with the office **FINANCIAL POLICY**
2. I understand and agree to the **GENERAL CONSENT TO TREATMENT**
3. I authorize the **RELEASE OF INFORMATION**
4. I authorize **PHOTOGRAPHS** to be taken of me
5. I have received a copy of the office's **NOTICE OF PRIVACY PRACTICES.**

X_____Date: _____

Signature of patient, parent or guardian

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