THE ROOT CANAL GUY

*James Wolcott D.D.S*

american association of endodontists

# Financial Consent Form

**I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatment procedures and/or diagnostic methods provided to me.**

**As a courtesy to our patients, our office will help file insurance claims. However, we are not responsible for what the insurance company does or does not pay. I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 61 days after being billed by the dentist. If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the full charges of the treatment rendered. Dental claims are submitted promptly after treatment is rendered, in most cases electronically on the same date of service, and if not paid by the patient's insurance company by the 61st day after treatment, the patient will be billed in full.**

**I understand that the balance is subject to a finance charge of 1.5% annually, if not paid within 30 days of statement date and I may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection cost. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.**

**I, _____ hereby authorize payment of the dental plan benefits payable directly to James Wolcott D.D.S. I understand this does not absolve me from full responsibility for the full charges of the treatment rendered. Once the insurance company has paid, if there is a remaining balance, a statement will be mailed and payment in full will be due upon receipt of the statement.**

**We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $100.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.**

**Signature: _____ Date: _____**

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