LEONARD ORTHODONTICS

Office Policy Consents and Authorizations

*Initial each Line and Sign where indicated

General Consents

Examination and Radiographic Films:

_____ I understand that **I/ my child** will be receiving a dental examination from a state licensed Dentist who has undergone specialized training in the field of Dento-facial Orthopedics and Orthodontics. I give my consent and understand that digital radiographs (ex: panoramic, cephalometric) will likely be taken on the day of the appointment, as they provide necessary diagnostic information regarding a patient's diagnosis. I understand this will allow the Doctor(s) to provide a thorough Orthodontic evaluation and enable them to make the necessary recommendations at that time.

Additional Diagnostic Services:

_____ I understand and give my consent/consent on behalf of my child, to undergo additional diagnostic procedures to complete Diagnostic Records necessary for my /my child's Preliminary Workup & Treatment Planning. I give my consent for Leonard Orthodontics to submit all diagnostic services rendered to my insurance carrier, which I have provided to their office.

_____ I hereby authorize the dentists and staff at LEONARD ORTHODONTICS to perform diagnostic services including an examination, x-rays, photographs, and models, when necessary, as the standard of care to properly diagnose and record any and all Orthodontic conditions. I understand that all of the above treatments are the standard of care in Orthodontics. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.

_____ I authorize LEONARD ORTHODONTICS and their staff to release any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such Orthodontic care to third party payors, health practitioners and as required by law.

Appointment Policy

Cancellations and No-Show Policy

In consideration of other patients' needs, please be courteous and call our office promptly if you are unable to make your appointment; we require 48-hour notice. This will allow us to offer your reserved appointment to a patient in urgent need of treatment and promptly reschedule your child for another appointment date. Excessive Cancelations, Broken or No-Show Appointments may lead in dismissal from the practice. _____

Appointment Reminder Services

To improve communications with our patients, Leonard Orthodontics will be emailing, calling, and/or texting appointment reminders. Please be aware that this information may also be used to email you personal information (i.e. Receipts, Invoices, Letters) relating to your dental care. Your information is only used for communications with you and other dental professionals. We do NOT share or sell personal information. _____

Medical Photography Consent

I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and Orthodontic treatment. _____

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Financial & Insurance Policies

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_____ I agree and consent to the assignment of benefits to Leonard Orthodontics and their Providers, that otherwise would be payable to me for services rendered. I assume and understand that I am financially responsible for all necessary services associated with pre-treatment workup diagnostic services and orthodontic treatment rendered to me/my child.

_____ I understand the office considers the ACCOMPANYING PARENT OR GUARDIAN as the FINANCIAL GUARANTOR, regardless of divorce settlement. Divorced parties must make separate payment arrangements amongst themselves and without the involvement of the office. We apologize for any inconvenience this may cause.

_____ I understand Insurance plans vary greatly and coverage is determined by the Subscriber's Specific Plan they have chosen through their Employer. Each Insurance Company arbitrarily selects certain dental services that they will and will not cover. I understand that obtaining insurance coverage and benefit information is ultimately my responsibility and **not the responsibility** of the Provider or the associated Orthodontic Practice.

_____ I understand it is my sole responsibility to review the Subscriber's Plan Coverage Certificate or booklet for specific details regarding my /my child's Plan coverage, orthodontic benefits, deductibles, annual maximums, waiting periods, limitations and exclusions. I understand that I am financially responsible for all unpaid insurance balances associated with orthodontic services rendered to me or my child.

_____ When applicable, Orthodontic Treatment Plan fees, which include services associated with pre-treatment diagnostic procedures and orthodontic treatment will be provided to me prior to starting treatment. I understand the office will provide **estimated amounts for anticipated** insurance payments based on the **patient's eligibility for coverage at that time. This is not a guarantee of your insurance's final payment amount.**

_____ I understand it is my sole responsibility to keep the office fully informed and up to date on any changes or termination of coverage to my dental insurance.

_____ In the event Coordination of Benefits will be necessary between multiple insurance carriers I may have coverage with, I understand that before benefits can be processed for payment, copies of explanation of benefits from my primary insurance carrier will be needed by the Leonard Orthodontics and Staff to properly submit additional claims, on my behalf, with the other carriers I have insurance coverage with.

_____ It is my sole responsibility to keep the office fully informed and up to date with any changes or termination of insurance coverage.

_____ In the event Coordination of Benefits will be necessary between multiple insurance carriers I may have coverage with, I understand that before benefits can be processed for payment, copies of explanation of benefits from my primary insurance carrier will be needed by the Leonard Orthodontics and Staff to properly submit additional claims, on my behalf, with the other carriers I have insurance coverage with.

_____ I understand and agree to immediately submit payment and provide copies of Explanation of Benefits to Leonard Orthodontics and Staff for services rendered at the office in the event insurance benefits and the attached EOBs are sent directly to me or the Subscriber. It is my sole responsibility and not that of Leonard Orthodontics or Staff, to obtain and provide the office with the necessary paperwork for timely and proper claim submission to secondary or new insurance carriers the patient may have coverage with.

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Authorizations for Claim Submissions

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_____ I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection to this claim.

_____ I hereby authorize and direct payment of all dental benefits, otherwise payable to me, directly to the named Provider or Leonard Orthodontics.

X_____

Patient Name

X_____ _____

Patient/Parent Signature Date

X_____ _____

Witness/ LO Staff Signature Date

Please contact us if there are changes with your dental insurance company, plan termination or if the Subscriber has a change of employment so that we may keep accurate and current records of your account.
This consent is to remain in effect from the date indicated unless canceled in writing.