

**Master's Hand Dental**  
**Statement of Patient Financial Responsibility**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Master's Hand Dental appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibilities to Master's Hand Dental, for providing rehabilitative services to me or the above names patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Master's Hand Dental, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if Guarantor is not the patient)

**Co-Pay Policy**

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in the matter.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Treatment and Authorization to Release Information**

I hereby authorize Master's Hand Dental, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Master's Hand Dental to release to appropriate agencies, and information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

**Cancellation/No Show Policy**

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancelling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Master's Hand Dental, will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

**Self Pay**

I do not have health insurance and will be responsible for services rendered her at Master's Hand Dental. I agree to pay Master's Hand Dental, the full amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_