Financial Policy and Agreement

Thank you for choosing us for your dental needs! We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities. To confirm your understanding and agreement with our policies, please read the followingg.

Payment:

Payment in full is due at the time services are rendered unless prior financial arrangements have been made. We accept Visa, MasterCard, Debit and Cash. Personal cheques are not accepted.

Insurance:

Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of Insurance contracts, you are fully responsible for knowing your own insurance plan and what you are not covered for. Treatment is recommended based on what you need NOT on what you are covered for. As a courtesy, we will gladly send your claim electronically for you, on your behalf, to your insurance company providing that your company does allow electronic submission.

Minors:

A parent or guardian must accompany all minors to their dental appointments. The parent or guardian accompanying the minor is responsible for full payment.   In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit. It is not our responsibility.

Missed Appointments:

Once an appointment has been made a room is reserved specifically for you. Please be considerate and allow at least two business days to change or cancel an appointment in order to avoid a service fee.

Service Charges:

Service charges are applied on all overdue accounts. We understand temporary financial problems may affect timely payment of your balance in some cases.   In those situations we encourage you to communicate any such problems immediately to our Front Desk team at 519-668-6844; they can be reached during regular business hours.

Financial Consent and Authorization for Treatment

We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage; your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim.

I agree to pay all fees and charges for services rendered at Southwest Dental Care for myself and my family. I agree to pay all charges when presented with a statement, unless prior credit arrangements are agreed upon in writing.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balance on my account.

Print Name Signature Date

Electronic Communication Consent

☐ I agree to receive email and/or text messages from Southwest Dental Care which may include appointment confirmations, newsletters, upcoming events and important notifications.

**You can withdraw your consent at any time.*

Privacy Policy Consent

Information for our Patients

At Southwest Dental Care, all professional dental services are performed by licensed members of the College (the "Dental Professionals"), and all institutional health care services are performed independently by Dental Corporation of Canada Inc., under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Southwest Dental Care and Dental Corporation of Canada Inc. are each independent corporations for their respective services. One or more of our Dental Professionals has a financial interest in Dental Corporation of Canada Inc. By signing this form, the undersigned acknowledges and agrees that they have read and understood the information and disclosures set forth herein prior to any professional services being provided to the patient by any Dental Professionals of Southwest Dental Care.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. Should there be any change in either my health status or any other inform I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of this office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I, the undersigned, acknowledge that the Corporations are relying upon the information which I have provided being accurate and complete.

Signature	Name

Date	Signature of Witness