



Spencer B. Wagner D.M.D

Family & Cosmetic Dentistry, Orthodontics/TMJ
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Phone 801-426-6255 Fax 801-224-2966

I here by authorize and request the performance of dental services for myself or for the following dependant.

Name of Patient

Date of Birth

I also give my consent to any advisable and necessary dental procedures, medications, and anesthetic to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the service provided by the named, regardless of insurance coverage. I understand that all prices quoted to me by the dentist and all staff members are estimates, and are dependant upon insurance coverage. I understand that these estimates may change and they are not necessarily the set final price for dental treatment.

I understand that payment for all dental procedures is due at the time of service. In the event that the payment for services rendered is not made in full, I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balance, and a collection fee of 40% if my account is assigned to a collection agency. Payment is accepted in the form of cash, check, and all major credit cards, as well as Care Credit and Lifestyle Lendings.

I UNDERSTAND THAT A FEE OF \$30 WILL BE CHARGED FOR A MISSED APPOINTMENT MONDAY-THURSDAY UNLESS I NOTIFY THE OFFICE AT LEAST 24 HOURS IN ADVANCE. I UNDERSTAND THAT THIS FEE IS DOUBLED TO \$60 WHEN I DO NOT SHOW UP TO OR CANCEL AN APPOINTMENT WITHIN 24 HOURS ON A FRIDAY OR SATURDAY.

HIPPA REGULATIONS

I understand that under the Health Insurance Portability and Accountability Act of 1996, other wise know as HIPPA, I have certain rights to privacy regarding my protected health information. I understand that this information will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment form third parties
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have read, understand and agree to the provisions of this financial policy consent form and HIPPA agreement

Patient/Responsible Party Signature

Date

Witness

Date

Whom may we thank for referring you? _____