TREATMENT CONSENT FOR SERVICES NOT COVERED BY INSURANCE

Patient Acknowledgment

I have been informed that the dental treatment listed below is **not covered** by my dental insurance plan, **or** that the treating doctor is **not participating with my insurance plan**, and the services will therefore be provided on an **out-of-network** basis.

I understand that any estimated insurance benefits discussed with me are not a guarantee of payment. My insurance company will determine benefits according to the terms of my policy.

I understand that by choosing to proceed with the treatment listed below, I accept full financial responsibility for all charges associated with the treatment, including any additional charges that may be incurred during the course of treatment that are not covered by my insurance plan.

Treatment & Fees

Treatment	Fee
_____	$_____
_____	$_____
_____	$_____

_____ $_____
_ _

Patient Consent

I have had the opportunity to ask questions regarding my insurance coverage, estimated fees, and financial responsibility. All of my questions have been answered to my satisfaction.

By signing below, I acknowledge that I understand the financial responsibility associated with the treatment listed above and voluntarily authorize treatment.

Patient Name (Print): _____

Patient Signature: _____

Parent/Legal Guardian (if applicable): _____

Relationship to Patient: _____

Date: _____