Roane Dental Associates, P.C.

1855 Tanner Way, Ste. 210, Harriman, TN 37748

I understand and give my permission to Roane Dental Associates to perform diagnostic services to help better determine the appropriate treatment needed for my proper dental care. These diagnostic services may include any or all of the following: x-rays, oral examination, biopsy, periodontal evaluation, probing or any other necessary service to help Roane Dental Associates make an adequate diagnosis.

Once a diagnosis is made, I will be given a treatment plan. The purpose of this plan is to make more aware of the recommended treatment, the estimated cost of the recommended treatment and the anticipated financial responsibility of the recommended treatment. I understand that once the treatment is performed, if my insurance company denies the treatment, or if they pay less than expected, then I am responsible for any remaining balances. Furthermore, I understand and agree that my estimated portion of any and all treatment will be paid upon the day of services. Forms of payment include Cash, Visa, MasterCard, Discover, Personal Check, and Care Credit.

As a courtesy, Roane Dental Associates will file a Pre-Authorization, at my request, for any recommended treatment to help me better determine what I can expect my portion to be. Additionally, as a courtesy when the treatment is performed, Roane Dental Associates will file my insurance for payment. However, I understand and agree that if my insurance company fails to pay within 30 days, or if they pay less than expected, then I become immediately responsible for the balance remaining and will pay such balance upon receipt of statement. This office does not file secondary insurance coverage.

If my delinquent account results in collection proceedings, then all additional collection costs, court costs, and legal fees will be paid by me.

Roane Dental Associates reserves time, personnel and facilities just for me when I have an appointment scheduled. I understand and agree that Roane Dental Associates requires a 24-hour notice in advance of my scheduled appointment to avoid a $50.00 cancellation fee per appointment and patient.

I grant my permission to Roane Dental Associates to telephone me at home, work or cellular telephone to discuss matters related to my treatment, financial obligations or appointments.

_____ Signature of Patient
_____ Print _____ Date

_____ Signature of Parent (If Patient is a Minor)
_____ Print _____ Date