



Consent for Treatment

I authorize Dr. Micah Bickel or designated staff to take x-rays, study models, photographs, and other diagnostics as deemed appropriate diagnosis of my dental needs. Upon diagnosis, I authorize Dr. Bickel to perform any recommended treatment, mutually agreed upon by me, and employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications when necessary. I fully understand that use of anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Financial Policy

It is our policy for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following financial options:

Payment is due at the time of service. If you have insurance, only your estimated patient cost-share is due at time of service. We have an in-house dental plan for patients without insurance and are happy to give you more details upon request.

Treatment plans are an ESTIMATE ONLY, based on information given to us by you and your insurance company. In the event that your insurance company pays less than the estimated amount, you are responsible for the unpaid balance. All treatment cost remains your responsibility, regardless of insurance coverage. In the case that treatment changes this may result in additional charges and patient share costs

No Show, Missed Appointment Policy

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with **at least 48 business hours notice**. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

**There is a charge of \$100.00 per hour for late cancellations and missed appointments.*

**Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

I have read, and understand, and agree to the above Consent for Treatment, Financial, and No Show/Missed Appointment policies.

Signature: _____ Date: _____

Print Name: _____