**Informed Consent for Non-Covered Dental Services**

Patient Information:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Explanation*: As a patient at My Dental Home, we are committed to providing you with the highest quality dental care and ensuring transparency in all aspects of your treatment. It is important for you to understand that dental insurance plans vary widely in terms of coverage, limitations, and exclusions.

Despite our best efforts, there may be certain dental services and procedures that are not covered or fully reimbursed by your insurance plan. This may include but is not limited to cosmetic procedures, orthodontic treatment for adults, dental implants, and other elective treatments.

In order to proceed with any non-covered dental services, we require your informed consent and acknowledgement that you understand the following:

I understand that certain dental services and procedures may not be covered or fully covered by my dental insurance plan.

* I acknowledge that I will be responsible for the full cost of any non-covered services.
* I understand that any estimated insurance coverage provided by the dental practice is not a guarantee of payment, and actual reimbursement may vary.
* I acknowledge that it is my responsibility to verify my insurance benefits and coverage limitations prior to receiving any dental treatment.
* I understand that I have the right to seek alternative treatment options or delay treatment until my insurance coverage changes or improves.
* I acknowledge that My Dental Home will make every effort to provide accurate information regarding the coverage of dental services, but unforeseen circumstances may result in additional costs.
* I understand that payment is due at the time of service and that any outstanding balance not covered by insurance is my responsibility.

By signing below, I confirm that I have read and understood the contents of this Informed Consent for Non-Covered Dental Services. I further acknowledge that I have had the opportunity to ask questions and that any concerns have been addressed to my satisfaction.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_