Zachary M. Linkous, D.D.S.
2307 West AJ Hwy
Morristown, TN 37814
(423) 581-8020

FINANCIAL/ APPOINTMENT CONSENT FORM

We would like to take this opportunity to welcome you to the office of Zachary Linkous, D.D.S. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive dental care, we ask that you review and complete our office and financial policy consent form. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your treatment as much as possible.

If you have dental insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to file the claims and collect payment in a timely manner. It is the patient's responsibility to update the office on any changes of information. While we do our best to verify dental benefits on your first visit, this does not guarantee coverage or payments to our office. We do accept payments from the dental insurance companies however we are not contracted with them (otherwise known as "out-of-network"). It is a contract between you, your employer and the insurance company. The *only* insurances we are currently *in-network* with is Delta *Premier,* Delta *PPO,* Cigna *PPO,* Humana *PPO,* Blue Cross Blue Shield *PPO* and MetLife *PDP.*

Our office will provide you with an ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. It is possible to preauthorize any treatment to verify plan coverage and benefits at your request. However, please be aware that sending in a preauthorization can take up to several weeks to process by your insurance company and may delay treatment until processed.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as a dental care provider, our relationship is with you and NOT your insurance company. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the responsibility of the patient and / or account holder.

Payment / Co-pays / Deductibles

Payment for co-pays and/or deductibles is due at the time services are provided. We have several options for payment of services, which may be paid in the following manner:

1. Payment by cash, check, Visa, Mastercard, Discover
2. Payment by CareCredit. CareCredit is a bank financing program for qualified applicants who prefer additional time to pay their balance. It is a revolving line of credit through an independent financial institution. It is designed to meet the needs of our patients and is ideal for extended treatment plans, elective procedures, emergency care, and treatment not covered by insurance. CareCredit has financing options available that include 6 to 12 months interest free payment plans, as well as extended time with up to 2 years with an applicable interest rate.

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Account Balances / Charges
Returned checks will be subject to a service charge of $35.00. Any balance on an account older than 90 days will be subject to interest charges of 3% per month until the account is paid in full. If payment has not been received on the account during 90 days, the account risks being sent to a collection agency. Any and all attorney or collection fees incurred due to delinquency in payment will be charged to the patient. We do understand that temporary hardship may affect timely payment on your account. If this is a concern, we do ask that you contact us promptly for assistance in the management of your account.

Cancellations and Broken Appointments
In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 24 hour cancellation notice. Your scheduled time has been reserved only for you and the doctor and/or hygienist. Broken appointments waste staff's limited time and hinder our efforts to improve the oral health of the people we serve. If you are credited with 3 or more failed appointments that result in a loss for the practice of 3 hours or more, we reserve the right not to reschedule another appointment for you. A failed appointment is when a) you do not come to your appointment b) you arrive 15 minutes late or later for your appointment c) you do not cancel your appointment at least 24 hours in advance. Consideration will be given to emergencies and will be left to the discretion of the doctor and/or practice manager.

Reminder Calls
In an attempt to maintain an efficient schedule, our office routinely calls to confirm all appointments and mails reminder cards to the home address listed. We will always try to reach you at the number you have provided to us. In the event there is no answer at the time of the call and an answering machine or voice mail picks up, we will leave a message reminding you of your upcoming appointment. Should you be unavailable at the time of the call, and someone else answers, we may leave a message for you. We take every measure to ensure that your health information remain private and will never reveal the nature of your scheduled visit.

I have read and understand the above stated policies. By signing this consent form, I agree to the terms and conditions of the stated policies and also grant permission to the office of Dr. Zachary Linkous to mail to my home any items that assist the practice in carrying out any treatment, payment or related issues, such as reminder cards/letters and patient statements. I have the right to request certain restrictions on the above matters. I must provide this request in writing. I understand that the practice in not required to agree to my request, but if it does, is bound by the agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **Refusal to sign this consent/agreement, or revoking it, may result in the office of Zachary Linkous declining to provide any dental treatment to me.**

______________________________________ ___________________________

Patient or Guardian (must be 18 years old) **Date**