AS4U0716 -INSURANCE WAIVER & ACKNOWLEDGEMENT

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Insurance Waiver and Acknowledgement

Treating Dentist:

Insurance Non-Coverage Disclaimer Warning:
The Procedure is not covered by Dental Insurance and I agree and acknowledge that I am responsible for all fees associated with this service.

I further understand that by receiving the above mentioned procedure(s), that I am receiving specialized services that are not covered by my insurance.

• Pre and Post-Operative x-rays ____
• Laser Treatments ____
• Surgical Guide ____
• Extractions ____
• Alveoloplasty ____
• Implants and surgical parts ____
• Anesthesia ____
• Conversion of Temporary prosthesis ____
• Office Visits and examinations ____
• Implant Abutments ____
• Impressions ____
• Temporary and Final Prosthesis ____
• All dental laboratory fees ____

Waiver of Insurance Billing for this Additional Service

I am taking part in the Laser treatments provided to me by A Smile 4U. I will be receiving specialized services & I acknowledge that A Smile 4U will not bill my insurance for services provided under this arrangement. No forms will be produced now or in the future for insurance billing.

I have read the above statements and have received a copy (if requested), and recognize their importance in helping me with making my decisions. My signature indicates that I have read and understand this consent document. I recognize that failures can occur for various reasons and complications can occur in any procedure. I hereby grant authority to the doctor in charge to administer such procedures that may be deemed necessary or advisable in the diagnosis and/or treatment. I also certify that the information I submitted in the health questionnaire is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the

attending doctor and me, I will give that doctor the opportunity to resolve the problem. The risks and benefits associated with the above-referenced dental treatment have been thoroughly explained to me. I understand there is no certainty that I will achieve the desired benefits and/or results, and no guarantee has been made to me regarding the outcome of such dental treatment. In authorizing the above-referenced dental treatment to be performed, I understand that unforeseen conditions may occur during such treatment, which may necessitate a total change, extension or modification of the original treatment outlined above, or necessitate a different type of treatment than such authorized treatment set forth above. I therefore authorize and request that such treatment may be necessary and desirable in the exercise of my doctor's professional judgment. I have been informed that the dental treatment and/or procedures listed above may have both known and unforeseen risks, and no warranty or guarantee is made as to any results. Furthermore, I have been fully informed as to the nature of my dental treatment including other such care and treatment, along with the potential benefits, risks or side effects of such dental treatment, and the likelihood of achieving the desired results.

Signature of Patient, Parent or Guardian: _____