Financial Policy

Please Initial Each:

_____ *Our policy requires payment in full for all services rendered at the time of your dental appointment.* We allow up to **90 days** for payment to be made, after the 90 days you are fully responsible for all charges including any legal fees, interest charges and any other expenses incurred in collecting your account balance. If we send your balance to an outside collection agency, you will be responsible for an additional charge of $75.

_____ You understand that our office will provide **ESTIMATES ONLY** and can not figure an exact amount as insurance coverage does not guarantee payment or coverage. We do not offer any refunds, all refunds will be up to the doctor's discretion. Dentistry is unpredictable. Dr. Stokes always provides the best care with her patient's treatment. Unfortunately things can happen that are out of Dr. Stokes' hands. If a refund is issued, all lab costs and Dr. Stokes' time ($150/hour) will be deducted from, the total refund amount.

_____You understand that Dr. Stokes will treat her patients according to their complete dental needs and overall dental health, not according to dental insurance policies.

_____You authorize the staff to preform any necessary services needed during diagnosis and treatment. You authorize the staff to release any dental information. This is including copies of x-rays, dental charting, or treatment notes to your dental insurance company for review, per-determinations or to process dental claims for payment.

_____You understand that this is a dental office and Dr. Stokes **DOES NOT FILE WITH ANY MEDICAL INSURANCE**. We only file with Dental Policies. Any dental procedures that are covered under your medical policy are to be filed at your own discretion.

_____You understand that after your insurance company has completed and processed all dental claims and all adjustments/ discounts have been made. **YOU WILL BE RESPONSIBLE FOR ALL REMAINING FEES, REGARDLESS OF INSURANCE COVERAGE.**

_____ You understand that if any personal checks written to Dr. Stokes are returned to our office we will have a $50 return check fee applied to the account. Dr. Stokes will allow a two week period to take care of the return check portion. If the portion is not taken care of in the time allowed, the check will be sent to Tulsa County District Attorney's Office, Bogus Check Writer Division for prosecution. If this occurs, you will be dismissed from the practice and no future appointments will be scheduled.

IF YOU DO NOT HAVE INSURANCE COVERAGE YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED AT THE TIME OF SERVICE.

Patient Signature:__________________ **Date:**_____________

Print Patient Name:_________________ **Parent/Guardian if applicable:**________________

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

______________________________ ______________________________

Signature Date

____

Witness