Here at Dental Day, we strive to provide our patients with optimal care in a warm & comforting environment. We practice preventive dentistry, but also focus on caring for acute and chronic dental needs. We do our best to achieve early detection, early intervention, & prevention, and we hope to instill the same philosophy in our patients. Regularly scheduled office visits allow us to better assist you by identifying and managing potential dental issues more efficiently.

ACKNOWLEDGEMENT OF SELF-PAY STATUS - PATIENT RESPONSIBILITY

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay discount." A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and who will not be submitting the claim to an insurance carrier. You have requested that this service be coded as self-pay because (**initial one**):

_____ You have no health insurance.

_____ You have health insurance but you do not want your insurance billed and instead want to pay out of pocket.

_____ Other (please explain): _____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay service must be paid on the date of service.

- If you have insurance or other types of coverage, services received today that are included in the "self-pay" discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient or Representative Signature _____ Date _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____