

Consent for Examination, Treatment, and Assignment of Insurance Benefits

Our Office Policy Regarding Insurance Assignment, Consent for Examination & Treatment

Since your child is a minor, it is necessary that a signed permission form from a Parent or Legal Guardian be obtained before performing diagnostic and treatment procedures. Therefore the Parent or Legal Guardian has to be present in the office during the regular or emergency diagnostic examination. The diagnostic procedures will include necessary x-rays, cleaning/fluoride, and a thorough examination by the Doctor. I hereby give Fred C. Haeberlein, A.P.D.C. and Associates permission for my child to have diagnostic procedures. This consent for diagnostic procedures shall remain in effect until revoked by me in writing.

I hereby give Fred C. Haeberlein, A.P.D.C. and Associates permission to Treatment Plan the necessary dental treatment for my child. I understand that this treatment may include additional oral and x-ray diagnosis by the Doctor. I give my permission for the use of local anesthesia, nitrous oxide/oxygen analgesia, and behavior modification techniques for the safety and well being of my child. I understand that I will be personally informed of the diagnosis, Treatment Plan, materials, and procedures used to restore my child's teeth to their optimum condition. I will have the opportunity to ask any questions about the diagnosis and Treatment Plan before I give my final Informed Consent for Treatment.

I understand that there are some risks in the use of local anesthesia such as prolonged numbness, biting of soft tissue, and allergic reaction. I understand that there are some risks in the use of nitrous oxide/oxygen analgesia such as nausea, dizziness, and disorientation. I further understand that I can at any time request further consultation about any of the procedures used in this office and revoke in writing this Informed Consent for Treatment.

Signature of Parent, or Legal Guardian: _____ Date: _____

Witness: _____ Reviewed by Doctor: _____ Date: _____

Office Policy Regarding Insurance Assignment Is As Follows:

We will bill your insurance carrier after every visit as long as you are receiving care in our office. This courtesy may be withdrawn if circumstances warrant. You will need to sign this "Assignment of Benefits" form and other documents as required by your insurance company. Our office does not guarantee that your insurance will pay. We will make every attempt to get prompt verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. It must be fully understood that the contract is between you and your insurance company. If your insurance company requests additional information from you in order to process your claim, you agree to respond to your insurance company immediately. We would like you to send to us a copy of their request and your response to include in the chart.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO Fred C. Haeberlein, A.P.D.C.

I hereby authorize Fred C. Haeberlein, A.P.D.C. and Associates to furnish information to insurance carriers concerning all treatment and hereby assign all payments for dental services rendered to my child to Fred C. Haeberlein, A.P.D.C.

I hereby instruct the _____ Insurance Company to pay by check made payable and mailed

Insurance Company Name

directly to:

Fred C. Haeberlein, A.P.D.C. 1700 California Street Suite 200 San Francisco, CA 94109-4586

for the dental or medical expense benefits allowable, otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by Fred C. Haeberlein, A.P.D.C.

A photocopy of this assignment shall be considered as effective and valid as the original. This assignment shall remain in effect unless revoked in writing by the policyholder

I understand and agree that I am financially responsible for all charges whether or not paid by the insurance company. I authorize Fred C. Haeberlein, A.P.D.C. to release any information pertinent to my claim to any insurance company, adjuster, or attorney involved in this case to secure payment for services rendered. In the event of default, I agree to pay legal interest on the indebtedness, together with such collection costs and attorney fees as may be required.

Signature of Policyholder

Date: _____

Signature of Claimant, if other than Policyholder

Date: _____