HARVARD
School of Dental Medicine
HARVARD DENTAL CENTER

Financial Policy

I have received information about Harvard Dental Center's Financial Policy and this consent form is designed to provide a written confirmation thereof.

Teaching Practice

Payment is expected at time services are rendered. Pre-payment for services is required. An estimate of fees and consultation will be provided prior to commencing treatment. The Harvard School of Dental Medicine Teaching Practice contracts with certain insurance companies. Patient may be asked to provide personal identification that may include a picture I.D. and social security number to process dental insurance claims.

Patients who have commercial insurance, including MassHealth must bring in their insurance card and any forms their insurance company requires for reimbursement purposes. In addition, patients whose insurance companies do not cover 100% of services rendered may be asked to pay at time of service.

Patients who self-pay will be expected to pay at the time of visit. Patients with insurance are expected to pay their co-payment at each visit a co-payment is applicable.

Medicare has NO PROVISIONS for dental services. Patients will be financial responsible for any dental services they receive unless they have some kind of dental coverage.

Oral Surgery and TMD/Oral Facial Pain Patients only

Patients who are members of a medical managed care plan, including MassHealth MUST bring a referral number from their Primary Care Physician (PCP). Patients who do not bring a valid referral for a visit, which requires one, will be responsible for pay in full at the time of the visit. If you are unsure about whether you need a referral authorization, please contact your PCP. Patients who self-p ay will be expected to pay at the time of each visit. Patients with insurance, including MassHealth are expected to pay their co-payment at each visit. Medicare does pay our doctors for some of our Oral Surgery and TMD/Oral Facial Pain services under their medical plan. You most likely will need a referral from your PCP and prior approval of your treatment plan before services are considered eligible for reimbursement.

The undersigned certifies that she/he has read and is willing to comply with the foregoing, and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient's name: TESTER TEST DOB: 01/01/2000

Signature: _____ Date: _____

Address: 188 Longwood Ave , Boston MA

If the patient is under 18 years or incompetent to consent, *a parent or legal guardian of the patient with authority to give consent* must sign this Informed Consent.

_____ _____

Parent or Legal Guardian Signature Date

_____

Parent or Legal Guardian Name