Tracy Henson-McBee, D.D.S., P.A.
8705 Milwaukee Ave.
Lubbock, TX 79424
(806) 792-2171

Consent for Treatment

This CONSENT FOR TREATMENT is made and entered into this _____ day of _____, 20_____, by and between Dr. Tracy McBee, D.D.S, Staff, and _____ ("Client").

I hereby state that I have honestly and without exaggeration or omission, completed a health questionnaire, and I also state that I have or will before undergoing treatment, disclosed any and all information that might reasonably be considered relevant to decisions made by Dentist regarding my care. I have disclosed all past illnesses, particularly those that would affect my care. I also state that I have disclosed all medications that I am taking at the present time and will inform Dentist of any medications that may be prescribed now and in the future by physicians. I also state that I have disclosed the past or present use of any substances including prescribed drugs and not prescribed drugs, alcohol, steroids, vitamins, and dietary supplements.

I hereby hold harmless and waive any claim or defense against Dentist for any harm or injury I sustain as a result of my failure to fully disclose all relevant facts about my physical and medical condition to Dentist. I waive any claim or defense against Dentist for any harm or injury I sustain as a result of my failure to comply with the method of treatment and dosage schedule prescribed by Dentist. I agree to immediately cease any treatment prescribed by Dentist in the event of any adverse response or side effect arising from prescribed treatment and to provide immediate written notice of such adverse response or side effect to Dentist via fax to 806-780-9983. I agree to comply with prescribing instructions for use of all medications prescribed by Dentist.

I understand that the practice of dentistry is not an exact science and that diagnosis and treatment may involve risks of injury, including, but not limited to permanent injury and death. I acknowledge that no guarantees have been made to me as to the result of diagnostic testing and/or treatment by Dentist.

I acknowledge that neither Medicare nor Medicaid covers the services which I contemplate will be provided by Dentist, nor will not make a claim for payment or reimbursement for those services with these entities.
I also acknowledge that payment is due to Dentist at time of service for all services rendered and that this is an obligation independent of attempts by me to obtain insurance reimbursement.
I acknowledge that Dentist will not bill any third party payor for any dental services provided to me. I agree to pay all collection and attorney fees incurred should I fail to pay money owed to Dentist.

I have read and understand the forgoing Consent for Treatment and have signed the same as my voluntary act and deed.

Patient Name (Please print) _____

X _____

Patient, Parent, or Guardian Signature **Date**

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Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature **Date**

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____ Patient refused to sign

_____ Communication barriers obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other (Describe below)

_____

_____

Dental Insurance Information

** Dr. McBee is NOT an assigned provider for any insurance company (which means she is NOT in NETWORK.) You WILL be responsible for any balance remaining (including interest) after insurance payment. (Any account not paid within 30 days from the invoice date will accrue interest at the lesser of 1.5% per month or the maximum amount provided by law.) The fees quoted to you by our office are NOT a guarantee of payment but an ESTIMATE of the benefits available for the proposed services to be rendered. ** **DELTA DENTAL** insurance is **not** one that allows us to receive payments. Therefore, **patients with Delta Dental Insurance will be required to pay for the total cost of treatment upfront,** and Delta will then reimburse you.**

Policy Holder/ Subscriber Name (who the ins. is under): _____
Policy Holder Address: _____
_____
Employer: _____
Subscriber ID (SSN or ID#): _____
Group #: _____ Subscriber DOB: _____

DENTAL Insurance Company Information:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: _____

Do You Have any other **Dental** Coverage? Yes No
(If so, please fill out the next section also.)

Policy Holder/ Subscriber Name: _____
Policy Holder Address: _____
_____
Employer: _____
Subscriber ID (SSN or ID#): _____
Group #: _____ Subscriber DOB: _____

DENTAL Insurance Company Information:
Name: _____
Address: _____
City _____ State _____ Zip _____
Telephone Number: _____

X _____
Signature Date

Payment Guidelines/Financial Agreement

Our mission at MCB DDS is to provide excellence in dentistry that meets your individual needs. In order to reduce the cost of providing dentistry to our patients, **payment is expected at the time of service.**

The office of **Dr. Tracy Henson-McBee** will bill your insurance company for the dental care you have received. Due to the fact that **we are not in network** for any insurance plan, we will file your insurance as a courtesy for you. However, you as a patient will be responsible for **ALL BALANCES** (including interest) that the insurance company does not pay. Dr. McBee will employee the services of a collection agency for all balances that are 60 days past due after the receipt of your insurance company's payment. (Any account not paid within 30 days from the invoice date will accrue interest at the lesser of 1.5% per month or the maximum amount provided by law.) Your prompt attention to unpaid balances is greatly appreciated. The filing of insurance is **NOT** a **GUARANTEED** form of payment.

We are pleased to offer the following payment options: **(Please check #1 or #2.)**

☐ **Option #1** Non-assignment of benefits with payment in full.

-Payment is made in full by cash, check, Visa, MasterCard, or Discover with non-assignment of your dental benefits. We will process your dental insurance claim for you and have the payment sent directly to you.

☐ **Option #2** Assignment of benefits secured with your credit card.

-We will accept assignment of your primary dental benefits and **collect the co-payment at the time of service**. We will provide you with a copy of any secondary insurance claims for you to submit. A credit card will be kept on file to process any payment not reimbursed to us. (**You will receive a courtesy call before we charge your card for any balance.)**

- I hereby assign payment of my dental benefits directly to Dr. Tracy Henson-McBee, DDS, PA.

- I hereby authorize Dr. Tracy Henson-McBee, DDS, PA to process payment to my credit card of any outstanding balance occurred during the course of dental treatment to keep my account current.

Due to the varied insurances we accept, we must request that ALL patients be responsible for checking their policies for coverage limitations, referrals, deductibles, and co-pays.

COPAYS ARE DUE THE DAY OF YOUR APPOINTMENT.

* By signing this agreement, you agree to the terms of our insurance filing process and payment guidelines.*

CREDIT CARD INFORMATION

Card Type: Visa Discover Mastercard Amex CareCredit (Please circle one.)

Credit Card Number: _____

Expiration: _____ **Security Code:** _____ **Zip Code:** _____

The day we run your card for unpaid balance, what number is best to reach you? _____

Patient Name: _____

X _____

Signature Date