SOUTHERN ROOTS
PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

FLORENCE, KY
859.371.6543

FT. THOMAS, KY
859.441.4805

Medicare Opt-out

Last Name _____ First Name _____ Birthdate _____

Dentist Represents that we are excluded from participating under the Medicare Program both patient and dentist acknowledge that patient is not experiencing an emergency health situation.

Patient Acknowledges: Not to submit a Medicare claim or request Dentist to submit a claim even if they are covered under Medicare for any services provided.

Patient is fully responsible for payment of services and no reimbursement will be provided under Medicare for the services. The patient will be responsible for payment of servics at the Dentists' usual rate and regular payment agreements. Medicare and other supplemental insurance plans do not or may not elect to cover services as payment is not made under Medicare. Patient has right to have other providers provide services. Patient is not required or compelled to enter into private contracts that apply to other Medicare covered services furnished by other dentist who have not opted out. Patient agrees to reimburse Dentist for any costs and reasonable attorneys' fees that result from violation of the Agreement by patient and his/her beneficiaries.

Contract is in effect from date of signature until end of Dentist's end of opt out period.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred for their care. Financial responsibillity on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms as an out of network provider and/or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Patient understands that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ By checking this box, I understand the above information and agree with its contents.

Sign Here _____ Date _____