Advanced Education in General Dentistry Program (AEGD)

Patient Financial Information and Consent

As a patient serving clinic within an educational program, fees for dental services have been set and all payment is due at the time of services rendered.

We do **not** offer sliding scale fees or adjusted fees based on income. We are **not** a Medicaid or KanCare provider.

Please read, initial after each statement and sign at the bottom of the page:

1. Payment is due at time of services- Payment is due at the time of appointment. If a patient has insurance, the co-pay or out-of-pocket expense is due at time of service. _____

2. If a patient has dental Insurance- We are an in-network provider for the following insurance companies: Delta Dental, Blue Cross Blue Shield, Aetna, MetLife and Cigna. While we accept all private dental insurances, for those patients with out-of-network policies, payment is due in full at time of service. We will then file your claim and have your insurance company reimburse you. _____

3. Estimate of Payment- We provide a close estimate of patient out-of-pocket expenses. For any major dental service, we highly recommend a pre-determination be submitted to your insurance company. _____

4. Delinquent Accounts- If a patient elects not to pay a debt in full, or within 90 days, the account will be turned over to collection agency, which will report your name to the credit bureau and supplementary communications may use pre-recorded voice or texting to cellular or or wireless devices. Collection fees may be charged to your account, up to 33%. **Please note: as an institution of the State of Kansas, your name may be submitted tothe Kansas Setoff Program, resulting in any debt owed to be collected from state income tax returns/refunds. _____**

5. Appointment Cancellations/Failure to Show- We require a 24 hour notice for cancellations or rescheduled appointments. Failure to show for an appointment or cancel with 24 hours may be subject to a $50 Cancellation Fee that must be paid before rescheduling. If calling after hours to cancel, please leave a voice message so it can be retrieved the following day.

Patient Signature: _____Date:_____
Print Name: _____
Parent or Legal Guardian: _____