Patient Responsibility Statement

The objective of the Boynton Health Dental Department is to provide quality dental care at the lowest cost possible for students and staff, and faculty at the University of Minnesota. With this consideration, the following guidelines have been established.

1. Patient accounts are expected to be paid at the time of service. If you have dental insurance, we will submit claims to your insurance company. Any account balance after insurance payment will be your responsibility. Delayed payment by your insurance carrier is not a valid reason for delayed payment to our clinic.
2. Monthly payments on account may be negotiated with our Patient Financial Representative for qualified patients prior to dental treatment.
3. Credit cards are accepted for payment by our clinic.
4. Boynton Health Dental reserves the right to withdraw further routine care from patients if the patient does not fulfill the obligation made under financial arrangements. For Students: Failure to fulfill financial obligations will result in a HOLD on student academic records and/or the account balance transferred to the Student Accounts Receivable System (STARS) for billing and or collection (be advised that STARS may charge billing fees, late fees and collection fees).
5. As a patient in our clinic, it will be your responsibility to keep scheduled appointments. The clinic will require notification of cancellation at least 24 hours prior to the appointment or earlier if possible. This can be done by calling our clinic at 612-624-9998 (phone answered 24 hours).
6. The clinic will consider a "failed appointment" at any time a patient has not given the advanced notice required above or has failed to arrive within 10 minutes of their appointment time. When a patient fails two appointments in a 3-year period, the clinic will no longer schedule appointments for that patient.

CONSENT: I have read and accept the above responsibilities.

I authorize the staff of Boynton Health Dental Department to perform ordinary diagnostic procedures, including x-rays and photographs, to determine my dental condition; and to perform appropriate procedures for dental treatment provided the benefits, alternative, comforts and risks are explained fully to me before treatment is initiated. I understand that special prior consent will be obtained for non-routine procedures involving general anesthesia, sedation or potential complications.

I have read, understand and agree to the financial operations terms outlined above. I understand that I am financially responsible for charges and hereby guarantee full payment to Boynton Health Service regardless of whether I have dental coverage. I certify that I am at least 18 years of age and competent to sign this statement.

ASSIGNMENT OF BENEFITS

I authorize Boynton Health to release to my insurance carrier or other third party payer medical or financial information as needed to process claims submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes Boynton Health Service to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though I personally signed the particular claim.

I hereby authorize payment directly to Boynton Health.

Signature: _____

Date: _____