Arsmiles
FAMILY & COSMETIC DENTISTRY

Non Covered Services Informed Consent Form

I understand that the specific service(s) listed below are not covered by my insurance and are not included as part of another service.

- I choose to receive these specific services.
- I agree to pay for these specific services.
- All alternative procedures were explained to me in detail.

Procedure Name

I knowingly understand that the listed dental procedures may not be covered (paid) by my insurance company because the procedure(s) were considered medically not necessary.

The Dental office has explained to me, and I understand

- Why the procedures are needed.
- How much procedures will cost.
- What methods I can use to pay for the procedures.
- When I must pay the cost.

Signature *

Name *

First Name Last Name

Dental Services *

What dental service was provided?

Amount Paid *

How much did you Pay?

Phone Number *

Please enter a valid phone number.

Email Address *

example@example.com