Regional Headquarters:
25 Central Park West Suite 1Y
New York, NY 10023
(800) 715-9211

Financial Policies & Informed Consent

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Residents Name and Arbors Community

To ensure a pleasant experience with Go! Dental Services, we require acknowledgement of our financial policies and informed consent prior to starting treatment.

Initial visits will generally include a comprehensive examination, cleaning and x-rays. This will range in cost from $200 to $275.

Upon completion of the initial visit, a comprehensive treatment plan will be developed including recommended dental cleaning intervals, and any additional dental care that may be required.

A representative from Go! Dental Services will contact you to receive written consent and to discuss payment arrangements for any additional dental care recommended, prior to starting that care.

We will always make a good faith effort to provide an accurate estimate of the treatment fees associated with any suggested dental treatment prior to providing the care. Please understand that due to the complex nature of dental care, treatment plans may require changes due to clinical situations beyond our control. These situations may result in additional fees not initially anticipated.

Unless otherwise requested, all dental charges will be added to your monthly Arbors statement. Any other payment arrangements will need to be arranged prior to beginning treatment.

Please select your preferred billing method:

- ☐ Please add all dental charges to my monthly Arbors statement
- ☐ Please have Go! Dental Services charge all fees to the credit card below:

  Name of cardholder: _____

  Card #: _____

  Exp: _____ /_____ Sec. Code: _____ □ Please keep card on file
- ☐ Other: _____

AUTHORIZATION:
I have had the opportunity to read and review the Go! Dental Services Financial Policy and Informed Consent. I was given the opportunity to ask any questions I had. I acknowledge financial responsibility for the account in question, and I hereby authorize payment arrangements as indicated above.

Furthermore, I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes to medical status. I authorize the dental staff to perform the necessary dental services I may need, or authorize them on behalf of the patient if he/she does not make their own healthcare decisions.

_____ _____
Print Patient Name or Patient Representative Name Signature of Patient or Patient Representative