DELTA DENTAL®

www.DWPIowa.com

Dental Wellness Plan Member
Financial Responsibility Consent for Treatment

Consent for Treatment: I consent to the services offered to me through this form and as detailed below. I have been informed and understand the risks, benefits, financial responsibility and alternatives to these services. I understand that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made regarding the results of treatment.

Financial Responsibility: By agreeing to receive services that are never covered, **exceed frequency, or are over the Annual Benefit Maximum**, I understand that I will have to pay for services below.

Release of Information: I further authorize the release of necessary diagnostic, procedural and financial information as needed for the purpose of claiming insurance benefits. I understand that Delta Dental of Iowa shall have access to all information available from records maintained by this office.

Questions about benefits can be answered by calling Delta Dental at (888) 472-2793.

My financial responsibility per service (CDT procedure code, written description of procedure and charge per procedure code):

CDT Procedure Code	Description of Service	Billed Charge

Signing this certifies that I have read and understand the treatment to be provided and authorize that I am responsible for all financial responsibility as listed.

Patient Signature _____ DWP Member ID# _____ Date: _____

{Please retain this completed, signed consent form in the patient's record.}