POINT PLACE DENTAL
we love to see you smile

Dental Sleep Medicine
Financial information

Please read carefully:
(Your signature below means you agree)

- I understand that all charges incurred in this office are due at the time they are rendered.
- I understand that these fees may exceed the limit allowed by my insurance company.
- I understand that this office is not a provider for my insurance company, including Medicare, Medicaid, Workman's Comp, Champus or TriCare.
- I understand that I will be responsible to obtain a verification of benefits based on the codes provided below.
- I understand that I will be responsible to file my claim to my insurance company.
- I authorize the release of medical records or other information needed for the insurance claim.
- I will be provided with fees prior to receiving treatment and I understand that I have the option to seek treatment from a participating provider.

Patient/Guarantor Signature:_____ Date_____

Witness:_____ Date:_____

PLEASE CALL YOUR HEALTH INSURACNE COMPANY TO VERIFY YOUR BENEFITS BASED ON THESE CODES:

IDC-10 Code (diagnostic code): G47.33

CPT Code (procedure code): E0486

Fee for device (includes 90 days of adjustments): $3200

Provider: Alison Mlodik, DDS
NPI: 1295098200
715.544.1277