Notice of Non-covered / Non-payable Dental Products and Services

At our dental practice, we educate our patients on better/enhanced materials, technology, and medications that can enhance the comfort and longevity of the treatment. It is well-known that **INSURANCE WILL NOT PAY** for these options. We feel the opportunity to have better/enhanced materials, technology, and medications should remain the patient's choice and should not be dictated by insurance companies.

Because there are no standardized dental treatment codes (CDT Codes) for better/enhanced materials, technology, and medications, they are automatically deemed **"not covered"** and **"not payable"** by insurance companies. We believe in being transparent. We document, with clear descriptions, these better/enhanced services using our own **"C-Codes,"** which stay within the doctor/patient relationship and are **NOT** sent to insurance companies.

Patient Acknowledgment:

I understand that my dental discount/insurance company will not cover or pay for better/enhanced materials, technology, and medications, as documented by C-Codes, performed by my dental provider on my behalf at this time or in the future. By signing below, I acknowledge that I understand and agree that:

1. These better/enhanced materials, technology, and medications provided to me, or that will be provided to me in the future, have been verbally explained to me, and accompanied with a treatment plan, printed informational document(s), procedural consent forms, and/or informational consent with a refusal option on the same page.

2. I have freely chosen to self-pay for these better/enhanced materials, technology, and medications, as documented by C-Codes, knowing they are not covered by my dental discount/insurance plan.

I have read this **"Notice of Non-covered / Non-payable Dental Products and Services"** form and have had the opportunity to ask any questions I may have. Any questions I may have had about this form have been answered to my satisfaction.

_____
Patient's Name

_____
Signature of Patient, Legal Guardian
or Authorized Representative

_____
Date